

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05114

CERTIFICATE OF DEATH

05112

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN lb 6 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 10/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 519 Grant Place				d. STREET ADDRESS 519 Grant Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Albaugh Last 1. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Nov. 28- 1875 9. AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH Month April Day 29 Year 19 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Adams				14. MOTHER'S MAIDEN NAME Anna Grimes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220- 52-2188T		17. INFORMANT Address Frederick, Md. Mrs. Margaret A. Runkles-519 Grant Pl.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X Uremia DUE TO (b) hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHF							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964 to 4/29/67 19 67 , that (I) (we) saw the deceased alive on 4/29/67 19 67 , and that death occurred at 5:15 P.M. from causes and on the date stated above.							
22a. SIGNATURE A. Austin Pearre-Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/30/67	
22c. PHYSICIAN'S NAME (Type) Dr. A.A. Pearre-Jr.				22d. ADDRESS 804 Toll House Ave.-Frederick-Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF May 3-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		23d. LOCATION (City or Town) (County) (State) Rocky Ridge-Md.	
24. FUNERAL DIRECTOR M.R. Etchison & Son				ADDRESS Frederick, Md. 21701		25a. REC'D BY REGISTRAR MAY 5 1967	
				25b. REGISTRAR'S SIGNATURE Charles Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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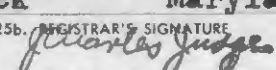
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

051115

051123

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b. 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland Frederick b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Pleasant view d. STREET ADDRESS Rt 1 Tuscarora e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Elmer Ambush First Middle Last Male Negro 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad 10b. KIND OF BUSINESS OR INDUSTRY ***** 11. BIRTHPLACE (County & State, or foreign country) Frederick Co, Md 12. CITIZEN OF WHAT COUNTRY? U.S.A.				4. DATE OF DEATH April 2 19 67 Month Day Year 5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Feb 3, 1912 Yrs. Months Days Min. 9. AGE (In years last birthday) 55 13. FATHER'S NAME Joseph Richard Ambush 14. MOTHER'S MAIDEN NAME Mary Agnes Barton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 705-07-7670 17. INFORMANT Mrs Mildred Ambush Rtl Tuscarora, Md Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pnaumonia DUE TO (b) Uremia Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Nephrosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease, Hypertensive Art. Scl. Ht. Dis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Frederick Maryland			
21. I certify that (I) (this hospital) attended the deceased from.....August....., 1966 to Apr.....2....., 1967, that (I) (we) last saw the deceased alive on.....4/2/67.....19....., and that death occurred at.....6:30 AM..... from the causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Gilcin F. Meadows				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 810 Toll House Ave Frederick, Md 22b. DATE SIGNED 4/4/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-5-1967		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City, town or county) Frederick (State) Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks, 111 Frederick, Maryland ADDRESS				25. REC'D BY REGISTRAR APR 5 1967 25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05113

Frederick

Marjorie

Frederick

Angel license view

2 days

Frederick

At 1 Treasurer

Frederick Memorial Hospital

Amos

Amos

Charles

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Feb 2, 1918

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Worce

U.S.A.

Frederick Co, Md

Frederick

Frederick

Mary Anna Barton

Joseph Richard Amos

701-07-7870 Mrs. Wilfred Amos, 701 Treasurer, Md

Amos

210 Tola House Ave Frederick, Md

Calvin S. Meadows

Marjorie

Frederick

Frederick

4-6-1967

Frederick

C. W. Nichols, III, Frederick, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05116

CERTIFICATE OF DEATH

05114

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 203 Brooklawn Apartments	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle CULLER Last AUSHERMAN		4. DATE OF DEATH Month April Day 22 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 8, 1903
9. AGE (In years last birthday) yrs. 63		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Secretary		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Jefferson, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Culler		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-9508	
17. INFORMANT Mr. C. Hubert Ausherman		Address Frederick, Md. 203 Brooklawn Apts.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Atherosclerosis, generalized DUE TO (c) 1.5 yrs			INTERVAL BETWEEN ONSET AND DEATH 1 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 16, 1967 , to April 22, 1967 , that (I) (we) last saw the deceased alive on April 22, 1967 , and that death occurred at 10:10 PM , from causes and on the date stated above.			
22a. SIGNATURE Henry V. Chase		22b. DATE SIGNED 4-22-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Henry V. Chase		22d. ADDRESS 804 Toll House Avenue Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-25-1967	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	23d. LOCATION (City or Town) (County) (State) Jefferson, Maryland
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR Frederick, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 27 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1968

INSTITUTE OF HEALTH

21112

APR 2 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

05117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05115

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 324 N. Bentz St.		d. STREET ADDRESS 324 N. Bentz St.	
3. NAME OF DECEASED (Type or print) John Jacob Ausherman		4. DATE OF DEATH 4 Month 25 Day 67 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1903
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dietary laborer		10b. KIND OF BUSINESS OR INDUSTRY hospital	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Ausherman		14. MOTHER'S MAIDEN NAME Alice Gaylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-24-7117	
17. INFORMANT Miss Edna Smith, Middletown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) CONGESTIVE HEART FAILURE DUE TO (c) CORONARY ARTERY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) Robert J. Thomas, M.D.		22. DATE SIGNED 4/25/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/27/67	
23c. NAME OF CEMETERY OR CREMATORY ocust ValleyCh. of God		23d. LOCATION (City or Town) (County) (State) Frederick Co., Md.	
24. FUNERAL DIRECTOR Gladhill Company, Middletown, Md.		25a. REC'D BY REGISTRAR APR 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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05118

CERTIFICATE OF DEATH

05116

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 462 West South Street	
3. NAME OF DECEASED (Type or print) Minnie XXXXXX Lucinda XXXXXX BARTLETT		4. DATE OF DEATH Month APR. Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1882
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jacob C. Hartman		14. MOTHER'S MAIDEN NAME Alice Virts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-54-0250	
17. INFORMANT Mrs. Ethel Spurlock		Address 462 W. South St. Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute coronary occlusion 4201 DUE TO (b) Ate pulmonary edema, recurrent DUE TO (c) Hypertensive cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 8 hrs 3 days 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUG. , 1962, to APR. 10 , 1967, that (I) (we) last saw the deceased alive on APR. 9 , 1967, and that death occurred at 5:20 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Ralph L. Michels		22b. DATE SIGNED Apr. 10, 67	
22c. PHYSICIAN'S NAME (Type) Ralph L. MICHELS		22d. ADDRESS Medical Ctr. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-13-1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE APR 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b sev. months		2. USUAL RESIDENCE (Where deceased lived, if institution, indicate before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick		d. STREET ADDRESS Route 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bernhardt A. H. Brust- Sr.		4. DATE OF DEATH April 2- 19 67		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21-1878		9. AGE (In years last birth day) 88 yrs.		IF UNDER 1 YEAR Months Days 88		IF UNDER 24 HRS. Hours Min. 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurseryman				10b. KIND OF BUSINESS OR INDUSTRY Own Business				11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George Brust						14. MOTHER'S MAIDEN NAME Salome Bielefeld											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. 214-34-7511A						17. INFORMANT Hermann B. Brust, Sr.-Route 7- Frederick, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-Sclerotic heart dis. 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surg Amp. leg-A-S gangrene Mar 1967; MYOCARD. INFARCT 1963														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1948 to 2 APR 1967 , that (I) (we) last saw the deceased alive on APRIL 1967 , and that death occurred at 8:30A from the causes and on the date stated above.																	
22a. SIGNATURE Charles H. Conley, Jr.						22b. DATE SIGNED Apr. 3-67											
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr.						22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Apr. 5-1967				23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery				23d. LOCATION (City, town or county) (State) Frederick, Md. 21701					
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son						25a. REC'D BY REGISTRAR APR 5 1967						25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
SM 1/65

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05120		05118	
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BEVERLY E. CARLSON		4. DATE OF DEATH Month Day Year April 10, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1951
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Herbert D. Carlson		14. MOTHER'S MAIDEN NAME Eleanor Cheesman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father Address Same as Item 2.		Herbert D. Carlson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure + u.v. DUE TO Cachexia - Malnutrition (b) DUE TO Chronic Brain Disorder - ? Arachnoiditis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert S. Thomas		22. DATE SIGNED 4-11-67	
EXAMINER'S NAME (Type) ROBERT S. THOMAS		Address (Street, city, town, or county) Frederick, Md?	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-17-67	23c. NAME OF CEMETERY OR CREMATORY Alexandria Natl Cem.	23d. LOCATION (City, town or county) (State) Alexandria, Virginia
24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 13 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

05121

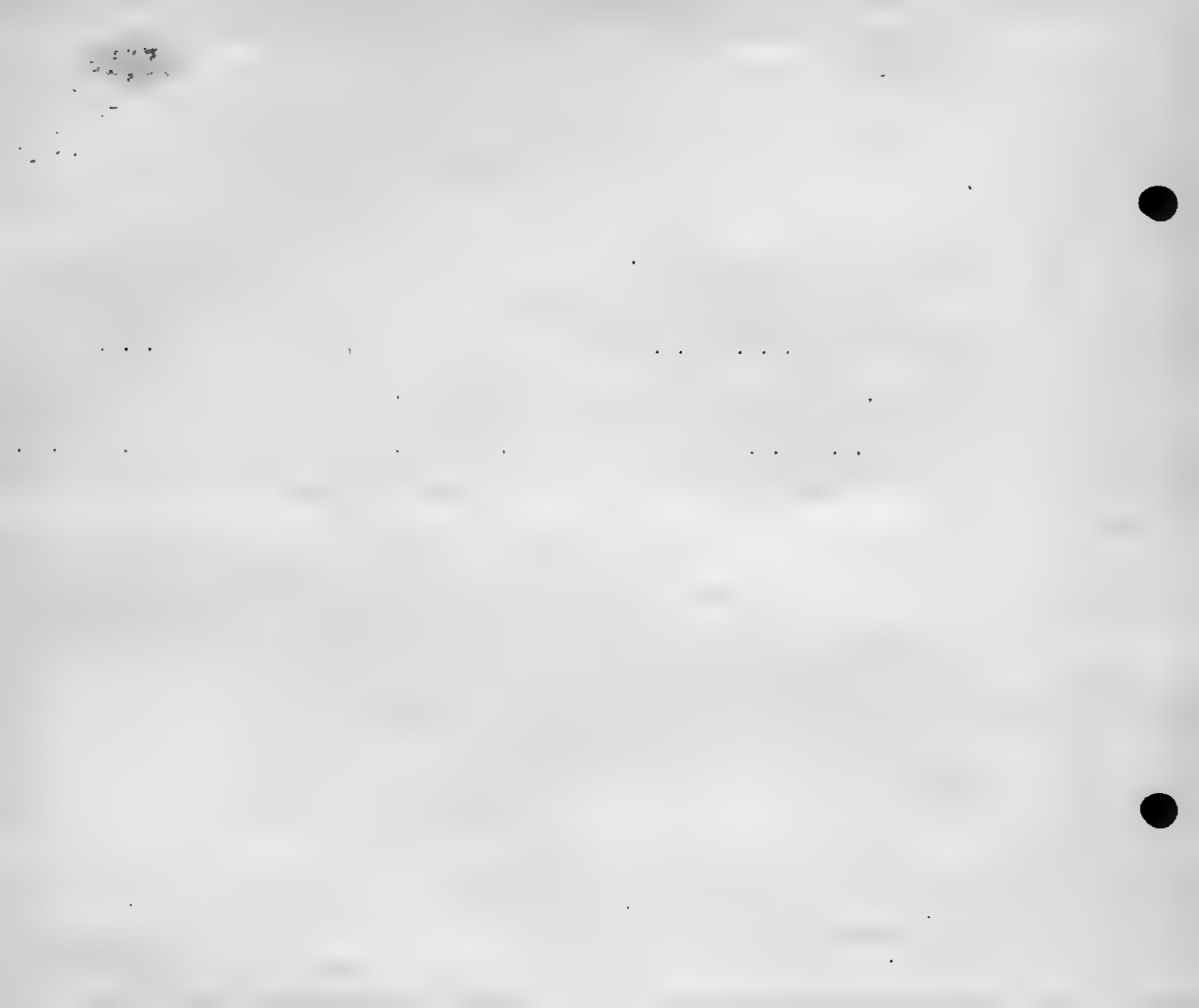
CERTIFICATE OF DEATH

05119

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Nursing Center		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 6 Fairview Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Percy C. CORNING		4. DATE OF DEATH Month April Day 4th Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Career Officer U.S.N.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	11. BIRTHPLACE (County & State, or foreign country) Chevy Chase, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward A. Corning	
14. MOTHER'S MAIDEN NAME Annie L. Reid		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. W.N. 1 W.W. 2 003-26-1883		17. INFORMANT Mrs. Ethel F. Corning 6 Fairvie Ave. Fred. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis, middle cerebral artery 240X DUE TO (b) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-3 1967 to 4-4 1967 , that (I) (we) last saw the deceased alive on 4-4 1967 , and that death occurred at 12 AM, from the causes and on the date stated above.			
22a. SIGNATURE Thomas E. Stone		22b. DATE 4-4-67	
22c. PHYSICIAN'S NAME (Type) Thomas E. Stone		22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-6-1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son		25a. REC'D BY REGISTRAR APR 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05122

CERTIFICATE OF DEATH

05120

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First HALLIE Middle MAY Last DANNER		4 DATE OF DEATH Month APRIL Day 6 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1921
9. AGE (In years last birthday) yrs. 45		IF UNDER 1 YEAR Months 8 Days 7 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.	
13. FATHER'S NAME Samuel Harn		14. MOTHER'S MAIDEN NAME Barbara A. Nicodemus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 60-44-2133	
17. INFORMANT Edward J. Danner		Address Randallstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 26 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ADENOCARCINOMA OF THE ENDOMETRIUM			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 3/11 , 19 67 to 4/6 , 1967, that (1) (we) lost saw the deceased alive on 4/6 , 1967, and that death occurred at 4/6 M, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 4/6/67	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS 804 Toll House Ave. Free, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/9/1967	23c. NAME OF CEMETERY OR CREMATORY Linsmore Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick Md.
24. FUNERAL DIRECTOR C. M. Waltz		25. REGD BY REGISTRAR APR 11 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05121

FOR STATE
HEALTH DEPT.

05123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before adm ssion) a STATE Maryland b COUNTY Frederick	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Brunswick		c LENGTH OF STAY IN 1b Brunswick	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		a STREET ADDRESS 8 South Maple Ave.	
3 NAME OF DECEASED (Type or print) First ERNEST Middle MILTON Last DAY		4 DATE OF DEATH Month 4 Day 5 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3/27/1886
9 AGE (In years last birthday) 81 yrs		10 UNDER 1 YEAR Months Days	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Henry Day		14 MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO unknown	
17 INFORMANT Mrs. Thelma Myers, Mt. Ranier Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR		INTERVA. BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas M.D. EXAMINER'S NAME (Type) Robert J. Thomas, M.D.		22. DATE SIGNED 4-5-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/8/67	
23c NAME OF CEMETERY OR CREMATORY Knoxville Cemetery		23d LOCATION (City or Town) (County) (State) Knoxville Maryland	
24 FUNERAL DIRECTOR Fete Funeral Home		25 REC'D BY REG STRAR APR 10 1967	
25b REG STRAR'S SIGNATURE John L. Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR; Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05125

05123

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Nursing Center				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 8 East Third Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle E Last Dietrich		4. DATE OF DEATH Month April Day 15 Year 1967		5. SEX Female			
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 16, 1891			
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (County & State, or foreign country) South Bend, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Desmond			
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or un-known) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-9842			
17. INFORMANT Mrs. Roy Gastley		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident X DUE TO Arteriosclerotic vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Frederick		(County) Frederick		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from July 1962 to April 15, 1967, that (I) (we) last saw the deceased alive on April 15, 1967, and that death occurred at 4:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Le Roy T. Davis M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/15/67			
22c. PHYSICIAN'S NAME (Type) Dr. LeRoy T. Davis		22d. ADDRESS 228 N. Market Street Frederick, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 4-18-1967		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION (City, town or county) (State) Mt. Airy, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Darrey & Son		ADDRESS Frederick, Maryland		25. RECD BY REGISTRAR APR 17 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

TO HONORARY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05126

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence at time of death) o. STATE Md b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memo Hospital		d. STREET ADDRESS Dickerson	
3. NAME OF DECEASED (Type or print) Telfair Bowie Dorsett		4. DATE OF DEATH Month April Day 25 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.20.1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (County & State, or foreign country) D.C.	
13. FATHER'S NAME William Dorsett		14. MOTHER'S MAIDEN NAME Roberta Coombs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 218.56.8459	
17. INFORMANT Helen J. Dorsett		Address Dickerson Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatous - abdominal cavity 1938 DUE TO (b) adenocarcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 3 yrs			INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 63 , to April 25, 1967 , that (I) (we) last saw the deceased alive on April 25, 1967 , and that death occurred at 4:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE Henry V Chase		22b. DATE SIGNED 25 April 67	
22c. PHYSICIAN'S NAME (Type) Henry V. Chase		22d. ADDRESS 804 Toll House Ave Frederick	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4.26.67	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d. LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a. REC'D BY REGISTRAR MAY 1 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dis. 05125

05127

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b Lifetime							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Nursing Home				d. STREET ADDRESS 116 E. 3rd. St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mrs Pearl Virginia Eades				4. DATE OF DEATH April 1 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25-1888	
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse				10b. KIND OF BUSINESS OR INDUSTRY ---			
13. FATHER'S NAME Edward M. Staley				14. MOTHER'S MAIDEN NAME Lauretta V. Angleberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220- 30-9174			
17. INFORMANT Mrs. Lucy Monk-				Address Route 3- Frederick, Md. 21701			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of the Bladder 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With Metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I attended the deceased from Nov. 29, 1966 to April 1, 1967 that I last saw the deceased alive on March 31, 1967 and that death occurred at 9 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearre Sr. M.D.				ADDRESS (Street, city or town, state) Frederick, Md.			
DATE SIGNED 4/1/67							
PHYSICIAN'S NAME (Type) A. A. Pearre-Sr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-3-1967		22c. NAME OF CEMETERY OR CREMATORY Anatomy Board- Johns Hopkins Hospital		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Elwood M.R. Etchison & Son				ADDRESS Frederick, Md. 21701			
24a. REC'D BY REGISTRAR DATE APR 3 1967				24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



05128

CERTIFICATE OF DEATH

05126

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodsboro rural	
c. LENGTH OF STAY IN 1b 4 hrs.		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN WM. ENGLE		4. DATE OF DEATH Month April Day 7 Year 1967	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-5-1904
9 AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TV & Radio repair		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard Engle		14. MOTHER'S MAIDEN NAME Bertha Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-26-8461	
17. INFORMANT Mary E. Engle		Address Woodsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart disease - Coronary Occlusion 4/201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hepatitis - Severe (2) Diabetes - Mild -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 3 , 19 67 , to Apr 7 , 19 67 that (I) (we) lost saw the deceased alive on Apr 3 , 19 67 , and that death occurred at 4:25 P.M. from causes and on the date stated above.			
22a. SIGNATURE James K. Gray		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James K. Gray		22d. ADDRESS Thurmont, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-10-67	23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cem.	23d. LOCATION (City or Town) (County) (State) Nr. Woodsboro Md. Fred
24. FUNERAL DIRECTOR Raymond G. Creager		25. REC'D BY REGISTRAR APR 11 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		CO.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

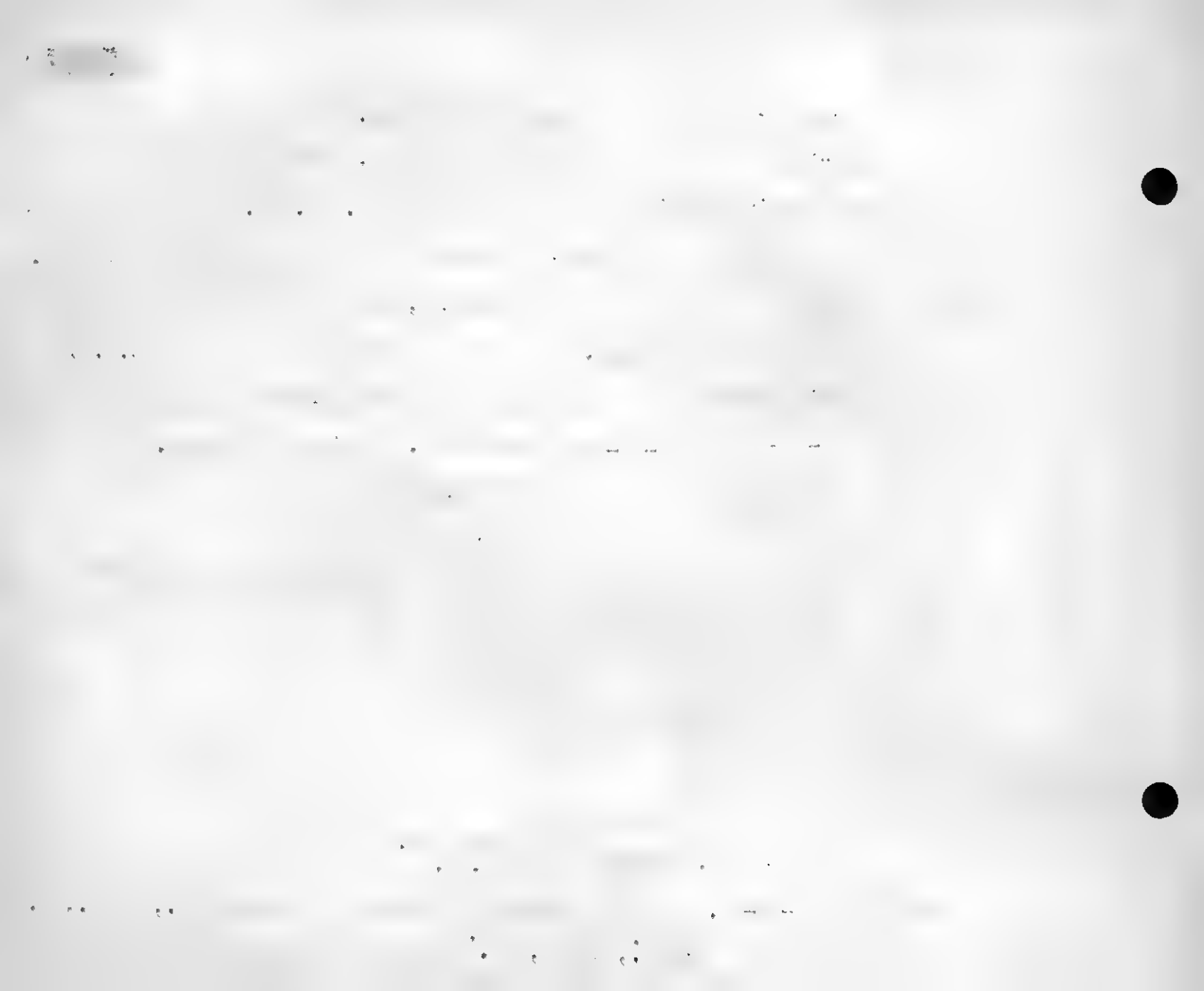
1000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
05129		05127							
1. PLACE OF DEATH a. COUNTY Frederick MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital					d. STREET ADDRESS Box # 356 . Rt. 2 .			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First MARY		Middle ELIZABETH		Last FIORINO		4. DATE OF DEATH Month April Day 19 Year 1967.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1903		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work			10b. KIND OF BUSINESS OR INDUSTRY At Home.			11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Cimino					14. MOTHER'S MAIDEN NAME Mary Ranazzo				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-22-0059		17. INFORMANT Dominio A. Fiorino		Address Same.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1979 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Bronchopneumonia DUE TO (c) Metastatic Malignancy - Type & site determined PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									22. DATE SIGNED 4-19-67
ACTUAL SIGNATURE Robert J. Thomas			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Toll House Ave. Frederick, Md.						
EXAMINER'S NAME (Type) Robert J. Thomas			Address (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-22-67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town or county) (State) 4430 Belair Rd., Balto., Md.			
24. FUNERAL DIRECTOR Charles S. Zeiler			ADDRESS 901 S. Conkling St. Balto., 21224, Md.			25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

05130

05128

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 4 c. LENGTH OF STAY IN lb Years		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route # 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 4, Frederick, Maryland		d. STREET ADDRESS Route #4, Frederick, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OSCAR DANIEL FISHER		4. DATE OF DEATH Month Day Year APRIL 7 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1904
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days 1967 Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Frederick City	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Daniel L. Fisher		14. MOTHER'S MAIDEN NAME Lidia Summers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 219 20 1152	
17. INFORMANT Mrs. Pearl Fisher (Same as item #2)		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho-sarcoma, acute 1967 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Frederick, Maryland	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1967 to April 7, 1967 that (I) (we) last saw the deceased alive on April 6, 1967 , and that death occurred at 7:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE B. O. Thomas, Jr. M.D.		22b. DATE SIGNED April 7, 1967	
22c. PHYSICIAN'S NAME (Type) B. O. Thomas, Jr. M. D.		22d. ADDRESS 228 N. Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05131

CERTIFICATE OF DEATH

05129

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1188 N. Market St.		d. STREET ADDRESS 1188 N. Market St.	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Sawyer Hahn- Sr.		4. DATE OF DEATH Month Day Year April 25- 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Apr. 10-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor		10b. KIND OF BUSINESS OR INDUSTRY -----	11 BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.
13. FATHER'S NAME Charles N. Hahn		14. MOTHER'S MAIDEN NAME Ida Sawyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 216- 22- 7629	
17 INFORMANT Mrs. Rebecca M. Hahn-1188 N. Mkt. St.-		Address Frederick-Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 60 Sec.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-16- , 19 63 , to 4-20- , 19 67 , that (I) (we) lost saw the deceased alive on 4-25- , 19 67 , and that death occurred at 5:45 P.M., from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 4-26-1967	22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds
22d. ADDRESS 804 Toll House Ave.-Frederick, Md. 21701			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-28-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR Elwood T. Whitmore ADDRESS Frederick, Md. 21701	
25b. REGISTRAR'S SIGNATURE APR 28 1967			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

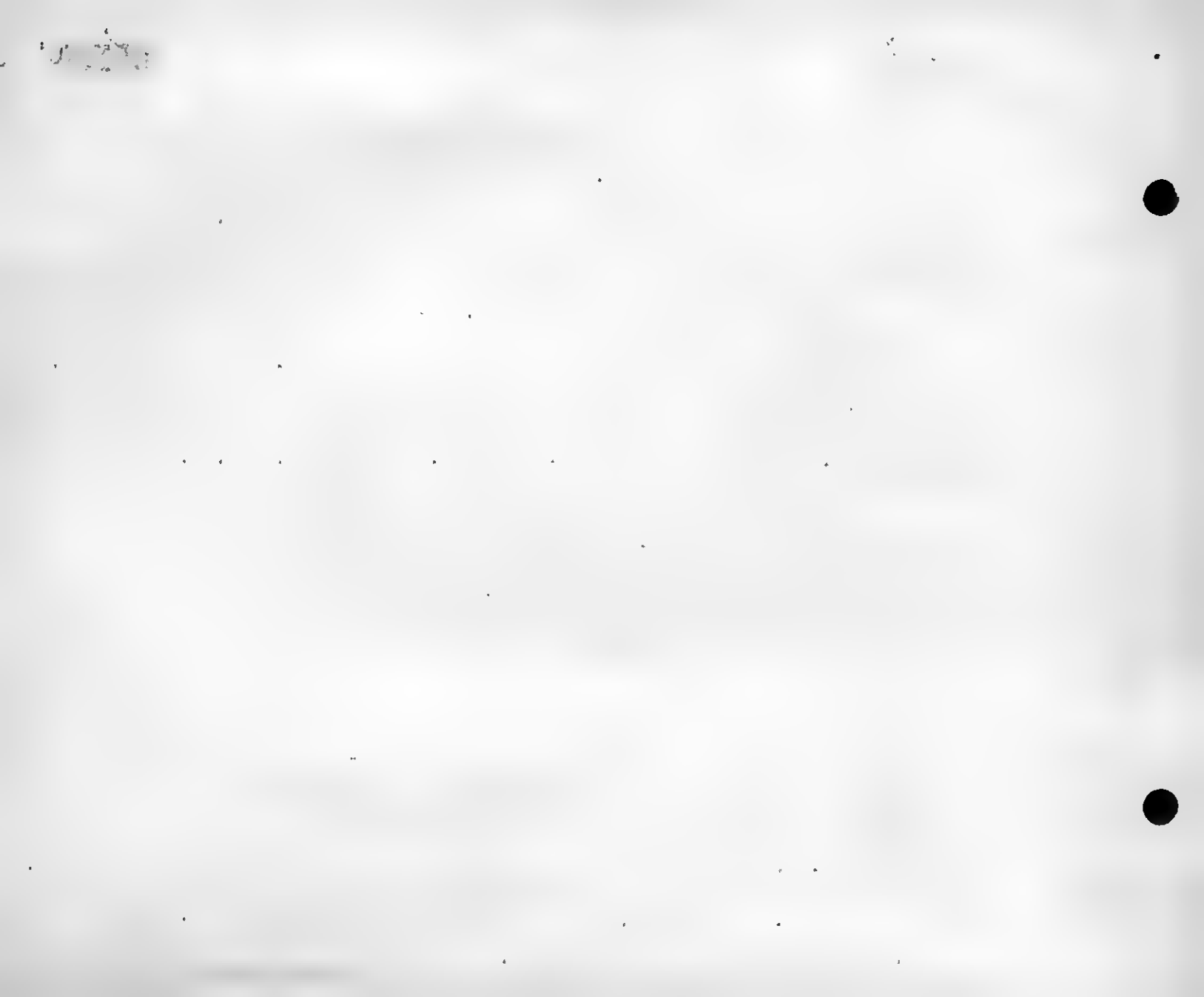
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05132

CERTIFICATE OF DEATH

05130

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				d. STREET ADDRESS 18 West South St.			
3. NAME OF DECEASED (Type or print) First Paul Middle Andrew Last HOBBBS				4. DATE OF DEATH Month APR. Day 21 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20-1896	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min 	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dairyman			10b. KIND OF BUSINESS OR INDUSTRY Retail Dairy		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Philip R. Hobbs				
14. MOTHER'S MAIDEN NAME Laura Jane Haugh				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. War 1			
16. SOCIAL SECURITY NO 218-30-9611A				17. INFORMANT Mehrle L. Hobbs-313 N. Mkt. St.-Frederick-Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Cerebral Infarction DUE TO (c) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 15 hrs 16 hrs 10 yrs.
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive OS HD							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from OCT. , 19 54 , to APR 21 , 19 67 , that (I) (we) last saw the deceased alive on APR. 21 , 19 67 , and that death occurred at 3:40 PM , from causes and on the date stated above.				
22a. SIGNATURE Rafel L. Michels, M.D.			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED APR. 22, 67		
22c. PHYSICIAN'S NAME (Type) Dr. R. Michels			22d. ADDRESS Frederick Medical Center-Frederick-Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 24-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.R. Etchison & Son			ADDRESS Whitmore Frederick, Md. 21701		25a. REC'D BY REGISTRAR APR 24 1967		
25b. REGISTRAR'S SIGNATURE J. Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
051331															
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN b. 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montevue County Home						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middletown d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Joseph			First J.			Middle Hoffman			Last Hoffman			4. DATE OF DEATH Month 4 Day 20 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/1903		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) truck driver, ret.				10b. KIND OF BUSINESS OR INDUSTRY transportation				11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Lorin K. Hoffman						14. MOTHER'S MAIDEN NAME Minnie Palmer									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 212-10-8222				17. INFORMANT Donald Hoffman, Middletown, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. X DUE TO (b) Cerebral vascular accident (c) Arteriosclerotic vascular disease INTERVAL BETWEEN ONSET AND DEATH 5 years.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frederick, Md.		(County) Frederick		(State) Md.			
21. I certify that (I) (this hospital) attended the deceased from August 1965 to April 20, 1967 , that (I) (we) last saw the deceased alive on April 20, 1967 , and that death occurred at 7 A.M. from the causes and on the date stated above.															
22a. SIGNATURE Dr. LeRoy Davis						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/21/67					
22c. PHYSICIAN'S NAME (Type) Dr. LeRoy Davis						22d. ADDRESS Frederick, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery				23d. LOCATION (City, town or county) (State) Myersville, Fred., Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.						ADDRESS		25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

1450

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05134

05132

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS Carroll Heights e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mildred Middle Rowe Last Hoover				4. DATE OF DEATH Month April Day 13 Year 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/1900		9. AGE (in years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William H Rowe				14. MOTHER'S MAIDEN NAME Bessie Poulton							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 144-30-4302		17. INFORMANT Address Mad. Cyrus R. Hoover, Carroll Heights, Taneytown							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Adeno Carcinoma to</i> DUE TO <i>Brain, bones skull, spine, pelvis, femur</i> (b) <i>Adeno carcinoma right breast</i> DUE TO (c) <i>5 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <i>variable</i> <i>5 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1967</u> to <u>April 13, 1967</u>, that (I) (we) last saw the deceased alive on <u>April 13, 1967</u>, and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <i>Jesse S. Fifer</i>								22b. DATE SIGNED April 13, 1967			
22c. PHYSICIAN'S NAME (Type) Jesse S. Fifer								22d. ADDRESS Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/1967		23c. NAME OF CEMETERY OR CREMATORY Lorriane Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR ADDRESS <i>John M. Skiles</i> C.O. Fuss & Son Taneytown, Md.								25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05133

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Buckeystown		c. LENGTH OF STAY IN TOWN Several yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Buckeystown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Jonas Robert Kanode-(also Knode)				4 DATE OF DEATH Month Day Year April 19-- 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 30-1893	9 AGE (in years last birthday) 73 yrs	IF UNDER YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Kanode				14. MOTHER'S MAIDEN NAME Elsie Kreglow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-01-8846		17. INFORMANT Address Mrs. LaRu Byrd-Dance Mill Rd.-Phoenix-Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Cerebral Hemorrhage DUE TO (c) Hypertensive - AS HD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert J. Thomas		EXAMINER'S NAME (Type) Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4-19-67	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 22-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701	
24. FUNERAL DIRECTOR M.P. Etchison & Son		ADDRESS Whitmore		25a. REC'D BY REGISTRAR DATE APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1944



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05136

CERTIFICATE OF DEATH

05134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN 1b <u>Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montevue Infirmary</u>				2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keymar</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTIE HESTOR KAUFFMAN</u>				4. DATE OF DEATH Month Day Year <u>April 28 19 67</u>									
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>September 4, 1872</u>		9 AGE (In years last birthday) yrs <u>94</u>		10 UNDER 1 YEAR Months Days Hours Min. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>			
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11 BIRTHPLACE (County & State or foreign country) <u>Frederick County, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Martin L. Kauffman</u>						14 MOTHER'S MAIDEN NAME <u>Sara Mercer</u>							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Arthur Strine, Route # 5, Frederick, Md.</u>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arterio-sclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____										INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>15 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1954</u> , to <u>April 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 28, 1967</u> , and that death occurred at _____ M, from causes on and on the date stated above.													
22a. SIGNATURE <u>Bernard O. Thomas, Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 1, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Bernard O. Thomas, Jr. M.D.</u>						22d. ADDRESS <u>228 N. Market St. Frederick, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Hope Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Woodboro, Maryland</u>			
24 FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MAY 9 1967

100



05137

CERTIFICATE OF DEATH

05135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>8 1/2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>Main St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALTA BESSIE KEENEY</u>		4. DATE OF DEATH Month Day Year <u>April 16 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1901</u>
9. AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Smith</u>		14. MOTHER'S MAIDEN NAME <u>Alice Beard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-48-2650</u>	
17. INFORMANT <u>Mrs. Charlotte Gosnell, Walkersville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic cardio-vascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>12 hours</u> <u>several years</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>April 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>67</u> , and that death occurred at <u>7:53 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>E. A. Dettbarn</u>		22b. DATE SIGNED <u>4/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. A. DETTBARN</u>		22d. ADDRESS <u>Walkersville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>W. Woodstock Fred. Md.</u>
24. FUNERAL DIRECTOR <u>J. C. Barton, Walkersville, Md.</u>		25a. REC'D BY REGISTRAR OATE <u>APR 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05138 CERTIFICATE OF DEATH 05136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN TB <u>Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Nursing Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ijamsville</u> g. STREET ADDRESS <u>Ijamsville, Maryland</u> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frederick</u> <u>William</u> <u>KELLER</u> First Middle Last		4. DATE OF DEATH <u>APR</u> <u>10</u> <u>1967</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16, 1886</u> Year Month Day
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		9b. AGE (In years last birthday) <u>80</u> Years Months Days	
10a. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ijamsville, Maryland</u>	
13. FATHER'S NAME <u>Thomas Jefferson Keller</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Remick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 54 8412 J1</u>	
17. INFORMANT <u>Mrs. Lottie Keller</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Advanced coronary and cerebral arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>10-15 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia with delayed resolution in Feb/March 1967</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>Apr 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr 8, 1967</u> , and that death occurred at <u>2:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Ralph L. Michels</u> M.D.		22b. DATE SIGNED <u>Apr 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph L Michels</u>		22d. ADDRESS <u>Med. Center, Frederick, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Litchison & Son</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (6)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05139

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05137

1 PLACE OF DEATH a COUNTY Frederick MARYLAND				2 USUAL RESIDENCE (Where deceased lived, first ten years before admission) a STATE Maryland b COUNTY Frederick			
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Brunswick			c LENGTH OF STAY IN b		c CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Brunswick		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 East 'G' Street				d STREET ADDRESS same		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Albert William M. Kline				4 DATE OF DEATH Month 4 Day 23 Year 67		9 AGE (In years, last birthday) 79	
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 7/16/1887	
10a USUAL OCCUPATION (Give kind of work done during last year) Required, employee				10b KIND OF BUSINESS OR INDUSTRY B&O Railroad		11 BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Martin L. Kline				14. MOTHER'S MAIDEN NAME Hannah Burrier			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16 SOCIAL SECURITY NO. 705-12-2680		17 INFORMANT Ruth Fowler, Brunswick Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY HEMMORRHAGE DUE TO CARCINOMA lung. Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 8 MONTH (c)							INTERVAL BETWEEN ONSET AND DEATH Immediate
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert J. Thomas M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/26/67		23c NAME OF CEMETERY OR CREMATORY Park Heights		23d LOCATION (City or Town) (County) (State) Brunswick Maryland	
24 FUNERAL DIRECTOR For the Funeral Home				25a REC'D BY REGISTRAR APR 25 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

100

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05140

CERTIFICATE OF DEATH

05138

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b several yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 W. 3rd. St.				d. STREET ADDRESS 13 W. 3rd. St.	
3. NAME OF DECEASED (Type or print) Charles L. Kolb		4. DATE OF DEATH Month April Day 7 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16- 1890	9. AGE (in years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Home building		11. BIRTHPLACE (County & State, or foreign country) Frederick CoMd.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marion Augustus Kolb			
14. MOTHER'S MAIDEN NAME Ella Mae Baker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 214-10-3469		17. INFORMANT Olivet T. Kolb- 607 Grant Pl. Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June , 1965, to 4/7 , 1967, that (I) (we) last saw the deceased alive on 4/7 , 1967, and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE James B. Thomas		22b. DATE SIGNED 4-8-67		22c. PHYSICIAN'S NAME (Type) James B. Thomas	
22d. ADDRESS Prof. Bldg.-Frederick, Md. 21701		23a. REC'D BY REGISTRAR APR 11 1967			
23b. REGISTRAR'S SIGNATURE J. Charles Judge		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23e. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23f. DATE THEREOF 4-11-1967		23g. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23h. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23i. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23j. DATE THEREOF 4-11-1967		23k. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23l. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23m. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23n. DATE THEREOF 4-11-1967		23o. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23p. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23q. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23r. DATE THEREOF 4-11-1967		23s. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23t. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23u. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23v. DATE THEREOF 4-11-1967		23w. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23x. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23y. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23z. DATE THEREOF 4-11-1967		23aa. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23ab. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ac. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ad. DATE THEREOF 4-11-1967		23ae. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23af. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ag. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ah. DATE THEREOF 4-11-1967		23ai. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23aj. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ak. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23al. DATE THEREOF 4-11-1967		23am. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23an. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ao. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ap. DATE THEREOF 4-11-1967		23aq. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23ar. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23as. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23at. DATE THEREOF 4-11-1967		23au. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23av. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23aw. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ax. DATE THEREOF 4-11-1967		23ay. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23az. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ba. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ba. DATE THEREOF 4-11-1967		23bb. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bb. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bc. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bc. DATE THEREOF 4-11-1967		23bd. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bd. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23be. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23be. DATE THEREOF 4-11-1967		23bf. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bf. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bg. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bg. DATE THEREOF 4-11-1967		23bh. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bh. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bi. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bi. DATE THEREOF 4-11-1967		23bj. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bj. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bk. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bk. DATE THEREOF 4-11-1967		23bl. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bl. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bm. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bm. DATE THEREOF 4-11-1967		23bn. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bn. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bo. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bo. DATE THEREOF 4-11-1967		23bp. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bp. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bq. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bq. DATE THEREOF 4-11-1967		23br. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23br. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bs. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bs. DATE THEREOF 4-11-1967		23bt. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bt. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bu. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bu. DATE THEREOF 4-11-1967		23bv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23bw. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23bw. DATE THEREOF 4-11-1967		23bx. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bx. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23by. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23by. DATE THEREOF 4-11-1967		23bz. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23bz. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ca. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ca. DATE THEREOF 4-11-1967		23cb. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cb. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cc. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cc. DATE THEREOF 4-11-1967		23cd. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cd. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ce. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ce. DATE THEREOF 4-11-1967		23cf. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cf. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cg. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cg. DATE THEREOF 4-11-1967		23ch. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23ch. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ci. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ci. DATE THEREOF 4-11-1967		23cj. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cj. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ck. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ck. DATE THEREOF 4-11-1967		23cl. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cl. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cm. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cm. DATE THEREOF 4-11-1967		23cn. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cn. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23co. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23co. DATE THEREOF 4-11-1967		23cp. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cp. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cq. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cq. DATE THEREOF 4-11-1967		23cr. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cr. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cs. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cs. DATE THEREOF 4-11-1967		23ct. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23ct. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cu. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cu. DATE THEREOF 4-11-1967		23cv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cw. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cw. DATE THEREOF 4-11-1967		23cx. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cx. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23cy. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23cy. DATE THEREOF 4-11-1967		23cz. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23cz. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23da. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23da. DATE THEREOF 4-11-1967		23db. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23db. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23dc. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dc. DATE THEREOF 4-11-1967		23dd. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dd. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23de. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23de. DATE THEREOF 4-11-1967		23df. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23df. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23dg. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dg. DATE THEREOF 4-11-1967		23dh. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dh. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23di. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23di. DATE THEREOF 4-11-1967		23dj. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dj. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23dk. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dk. DATE THEREOF 4-11-1967		23dl. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dl. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23dm. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dm. DATE THEREOF 4-11-1967		23dn. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dn. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23do. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23do. DATE THEREOF 4-11-1967		23dp. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dp. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23dq. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dq. DATE THEREOF 4-11-1967		23dr. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dr. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23ds. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23ds. DATE THEREOF 4-11-1967		23dt. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dt. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23du. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23du. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		23du. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23dv. DATE THEREOF 4-11-1967		23dv. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23dv. LOCATION (City or Town) (County) (State) Frederick, Md. 					

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100

100

CERTIFICATE OF DEATH

05139

05141

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b Frederick d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Mem. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD d. STREET ADDRESS Ijamsville, Md. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel L. LAWSON		4. DATE OF DEATH April 25 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Browningsville, Md.
13. FATHER'S NAME Miel E. Linthicum		14. MOTHER'S MAIDEN NAME Mary L. Purdum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	17. INFORMANT Ivan T. Lawson, Item 2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 4/25 , 19 67 to 4/25 , 19 67 that (we) last saw the deceased alive on 4/25 , 19 67 , and that death occurred at 9:25 M, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds, M.D.		22b. DATE SIGNED 4/25/67	22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M.D.
22d. ADDRESS 804 Toll House Ave. Frederick, Md.		22e. REC'D BY REGISTRAR MAY 2 1967	
22f. REGISTRAR'S SIGNATURE Charles Judge		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF April 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.	
23d. LOCATION (City or Town) (County) (State) Browningsville, Md.		24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

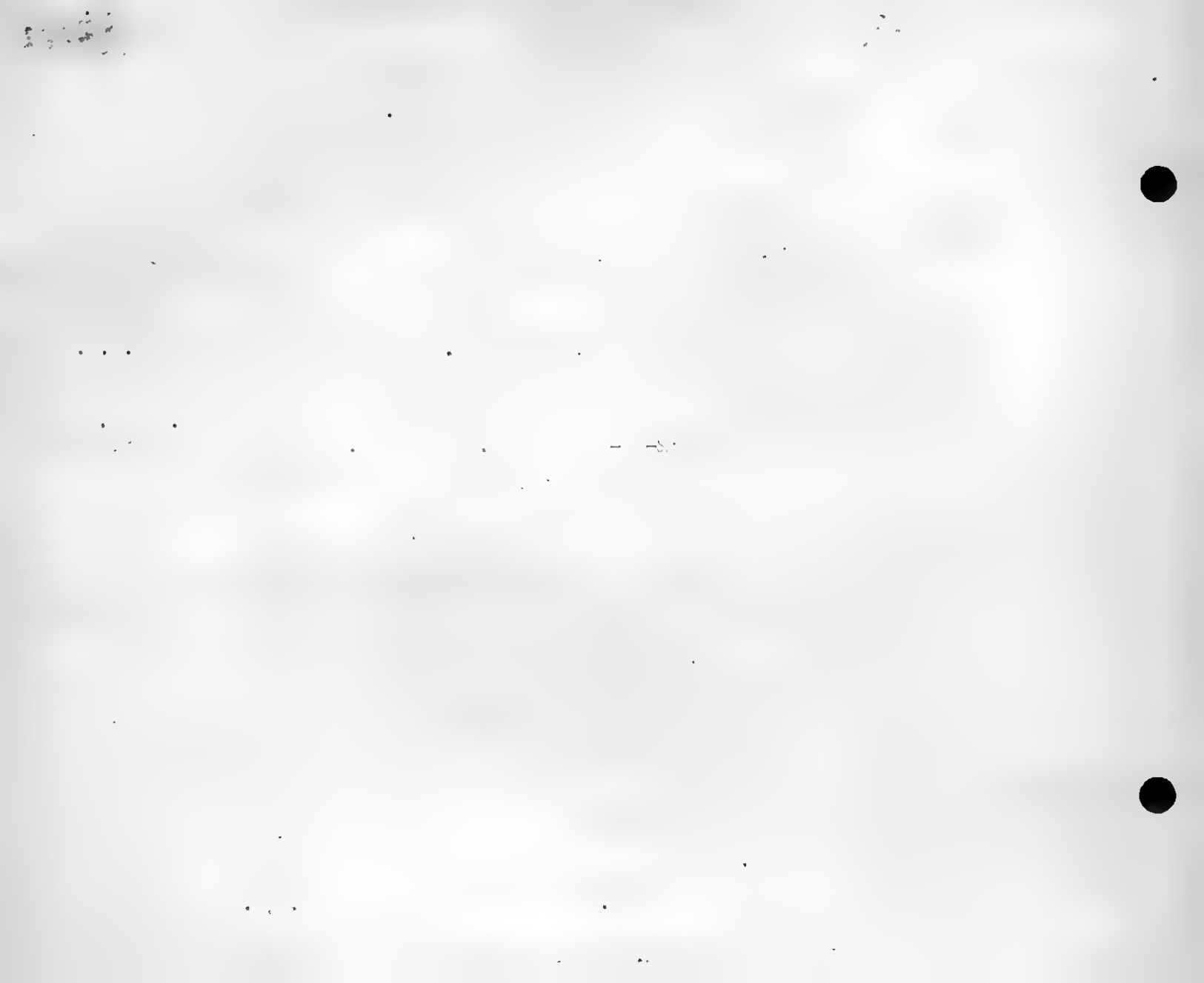
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05142

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05140

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21213 d. STREET ADDRESS 4612 Freedomway, West e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leon Hanson Loudermilk		4. DATE OF DEATH April 23 1967	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/44
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Trucking Business	11. BIRTHPLACE (State or foreign country) Md. Howard County
13. FATHER'S NAME Emory Loudermilk		14. MOTHER'S MAIDEN NAME Cora Barnett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-42-1216	
17. INFORMANT Mrs. Barbara L. Loudermilk		Address W. Balt. 21213	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure & Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive Hemorrhage DUE TO (c) Ruptured Spleen & Lac. Liver PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Subdural Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Lost control of automobile	
20c. TIME OF INJURY Hour a.m. 2:00 p.m. 4-23-67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Highway	20f. (City or town) (County) (State) Indevit - Frederick - Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) Robert J. Thomas		22. DATE SIGNED 4-23-67 M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/26/67	23c. NAME OF CEMETERY OR CREMATORY Balt. National	23d. LOCATION (City, town or county) (State) Balt. Md.
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown		25a. REC'D BY REGISTRAR APR 26 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge	



05143

CERTIFICATE OF DEATH

Reg. Dist. No. 05141

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville rural				c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital				d. STREET ADDRESS 110 W. Church St.			
3. NAME OF DECEASED (Type or print) Mary First hrivona Middle Last				4. DATE OF DEATH Month 4 Day 2 Year 19 67			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 3 1877	
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Wm. P. Maulsby-Jr.				14. MOTHER'S MAIDEN NAME Henrietta Hanson Pigman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-09-7855			
17. INFORMANT John Francis Smith				18. ADDRESS Irrington on Hudson- N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause ost. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from aug 16 , 19 56 , to apr. 2 , 19 67 that I last saw the deceased alive on apr. 2 , 19 67 , and that death occurred at 6:30p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-2-1967							
ACTUAL SIGNATURE Joseph Lerner				M.D. Ijamsville Md.			
PHYSICIAN'S NAME (Type) Joseph Lerner							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-1967		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Md. 21701	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son				ADDRESS Whitmore Frederick, Md. 21701		24a. REC'D BY REGISTRAR APR 12 1967	
				24b. REGISTRAR'S SIGNATURE J Charles Judge			

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

05144

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05142

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Frederick Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>Approx. 10 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>193 Carrollton Drive</u>		d. STREET ADDRESS <u>493 Carrollton Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Evelyn</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1920</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wif</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (in years last birthday) <u>46</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rex G. Good</u>		14. MOTHER'S MAIDEN NAME <u>Helen McNelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Joseph William McKelroy</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute and chronic alcoholism</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF DEATH Hour <u>am</u> Month <u>19</u> Day <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Robert J. Houser</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bainbridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bainbridge Pa. Lancaster Co.</u>
24. FUNERAL DIRECTOR <u>M.R. Etchison & Son</u>		25a. REC'D BY REGISTRAR <u>Edwood T. Whitmore</u> Frederick, Md. 21701	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



05145

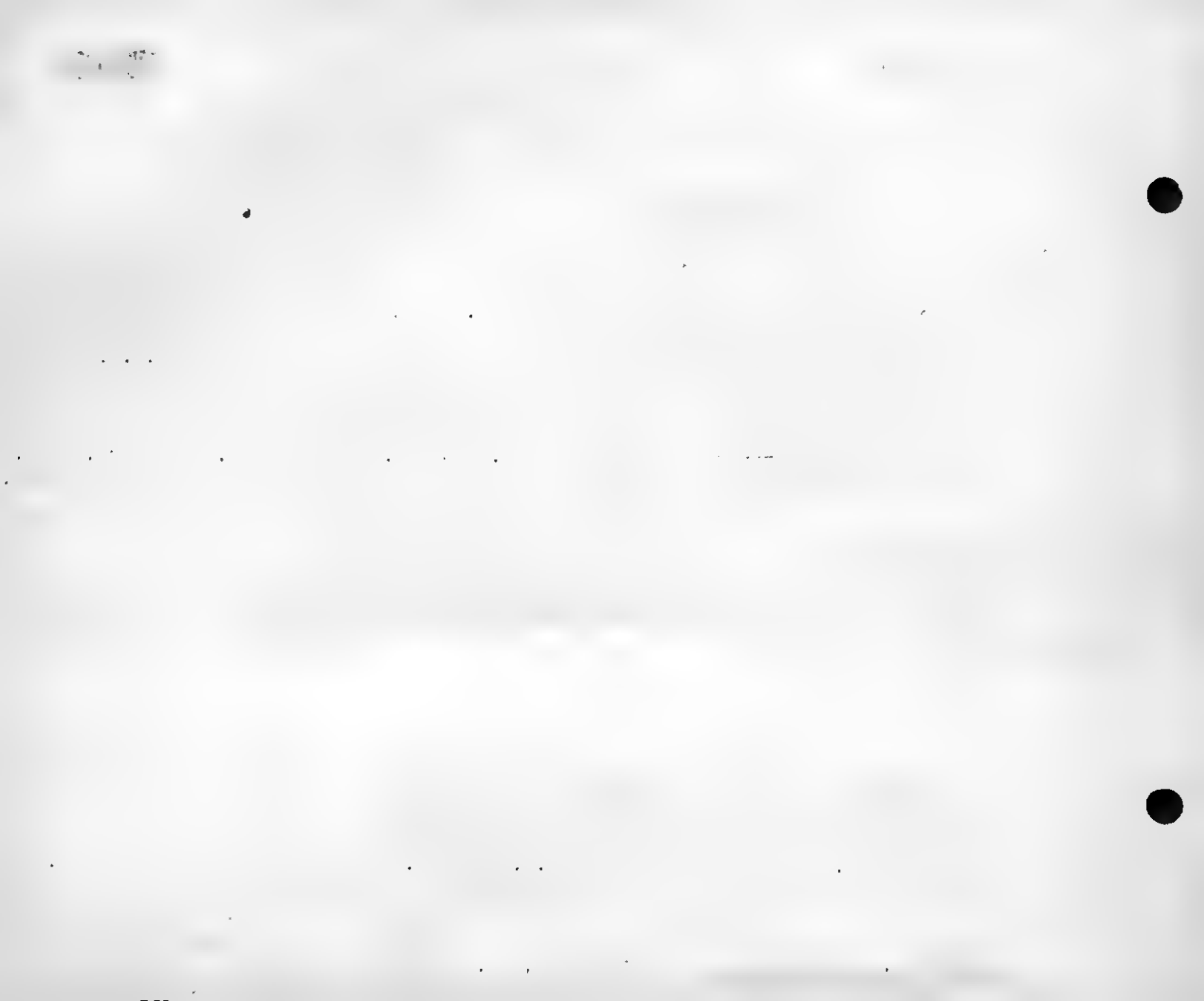
CERTIFICATE OF DEATH

05143

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 East Church Street		d. STREET ADDRESS 113 East Church Street	
3. NAME OF DECEASED (Type or print) DOSHUA GERTRUDE MILLER		4. DATE OF DEATH Month April Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1887
9. AGE (in years) 79		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Buchanan County, Virginia U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Jack Wagner		14. MOTHER'S MAIDEN NAME Annie Blackburn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Pearl F. Matney		Address 113 E. Church St. Fred.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 Severity with arteriosclerotic heart disease DUE TO (b) 4-6-1967 DUE TO (c) 3 1/2 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-11, 1967 , to 4-6, 1967 , that (I) (we) last saw the deceased alive on 4-6-1967 , and that death occurred at 4-6-1967 , M, from causes and on the date stated above.			
22a. SIGNATURE Rex R. Martin		22b. DATE SIGNED 4-6-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		22d. ADDRESS 220 N. Market Street Frederick, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25. REGD BY REGISTRAR APR 10 1967	
26. REGISTRAR'S SIGNATURE J. J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05146

CERTIFICATE OF DEATH

05144

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Emmitsburg		c. LENGTH OF STAY IN 1b 26 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 2		d. STREET ADDRESS R.D.# 2	
3. NAME OF DECEASED (Type or print) Kenneth Leo Miller		4. DATE OF DEATH April 1, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1941
9. AGE (in years last birthday) 26 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Miller		14. MOTHER'S MAIDEN NAME Mary B. Topper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Donald F. Miller, Emmitsburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent seizures DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital spastic disease - since birth DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 1941 to April 1, 1967 , that (I) (we) last saw the deceased alive on Feb 10 1967 , and that death occurred at 4 M, from causes and on the date stated above			
22a. SIGNATURE W R Cadle		22b. DATE SIGNED 4-1-67	
22c. PHYSICIAN'S NAME (Type) Dr. W. R. Cadle		22d. ADDRESS Emmitsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 5, 1967	23c. NAME OF CEMETERY OR CREMATORY New St. Joseph's	23d. LOCATION (City or Town) (County) (State) Emmitsburg, Frederick Co. Md.
24. FUNERAL DIRECTOR Clarence E. Wilson		25a. REC'D BY REGISTRAR APR 4 1967	25b. REGISTRAR'S SIGNATURE Charles J. J...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05145

05147

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montevue County Home		d. STREET ADDRESS RD 3	
3. NAME OF DECEASED (Type or print) Laura Florence Idella Miller		4. DATE OF DEATH Month April Day 20 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-1868
9. AGE (in years) 99 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Mort		14. MOTHER'S MAIDEN NAME Margaret Waldeck	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Charles H. Miller		Address Frederick, Md. RD 3	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) 2 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 9, 1967 to April 20, 1967 , that (I) (we) lost saw the deceased alive on April 20, 1967 , and that death occurred at 1:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE LeRoy T. Davis		22b. DATE SIGNED 4/21/67	
22c. PHYSICIAN'S NAME (Type) LeRoy T. Davis		22d. ADDRESS Professional Bldg. Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr 24 67	23c. NAME OF CEMETERY OR CREMATORY Wolica Cem	23d. LOCATION (City or Town) (County) (State) Wolica Fredk Co Md
24. FUNERAL DIRECTOR Raymond E. Crigger		25a. REC'D BY REGISTRAR APR 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

100



05148

CERTIFICATE OF DEATH

05146

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First GROVER Middle CLEVELAND Last MOSSBURG		4. DATE OF DEATH Month April Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1894
9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Manager	
11. BIRTHPLACE (County & State, or foreign country) Jefferson, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Mossburg		14. MOTHER'S MAIDEN NAME Fannie Burdette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. W. # 1		16. SOCIAL SECURITY NO 220 30 7786	
17. INFORMANT Mrs. Agnes Mossburg (Same as item # 2)		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Azotemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial failure DUE TO (c) Arterio-sclerotic heart dis			INTERVA. BETWEEN ONSET AND DEATH 38 days 1 mo. 1963
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus 1963; myocard. infarct. 1964			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 140 pr , to 140 pr , 19 67 , that (I) (we) last saw the deceased alive on 140 pr , 19 67 , and that death occurred at 5²⁵ p.m. from causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr. M.D.		22b. DATE SIGNED April 15, 1967	
22c. PHYSICIAN'S NAME (Type) Charles H. Conley, Jr. M. D.		22d. ADDRESS 228 North Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md		25. REC'D BY REGISTRAR APR 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05149

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05147

1. PLACE OF DEATH a COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Frederick	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		c LENGTH OF STAY IN TB 7 Years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 6		e STREET ADDRESS Route #6	
3. NAME OF DECEASED (Type or print) DAVID First SAMUEL Middle MOXLEY Last		4. DATE OF DEATH Month April Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1959 9. AGE (In years lost birthday) yrs 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Leesburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Bradley Moxley		14. MOTHER'S MAIDEN NAME Mabel Stream	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT George B. Moxley (Same as item #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 351X DUE TO (b) Epilepsy DUE TO (c) Cerebral Palsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas EXAMINER'S NAME (Type) ROBERT J. THOMAS		22. DATE SIGNED 4-11-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City or town) (County) (State) Beallsville, Maryland	
24. FUNERAL DIRECTOR Donald M. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR APR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

05150

CERTIFICATE OF DEATH

05148

1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN lb days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 113 South Market Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type of print) First GEORGE Middle CHARLES Last MYERS		4. DATE OF DEATH Month APRIL Day 13 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 11, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sales Driver		10b. KIND OF BUSINESS OR INDUSTRY None	11 BIRTHPLACE (County & State, or foreign country) Waynesboro, Pennsylvania
13. FATHER'S NAME Charles C. Myers		14. MOTHER'S MAIDEN NAME Maggie Bowers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-10-1268	17. INFORMANT Mrs. Mildred Myers 113 S. Market St. City
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) CHRONIC BRONCHITIS-			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1959 , 19 to 4/13 , 19 67 , that (I) (we) last saw the deceased alive on 4/13 , 19 67 , and that death occurred at 145/10 M, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 4/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. Richard C. Reynolds, M.D.		22d. ADDRESS 804 Toll House Avenue Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-17-1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S NAME (Type) Robert E. Dailley & Son		25b. REGISTRAR'S SIGNATURE Charles Judge	
25a. REC'D BY REGISTRAR APR 17 1967		25c. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05151

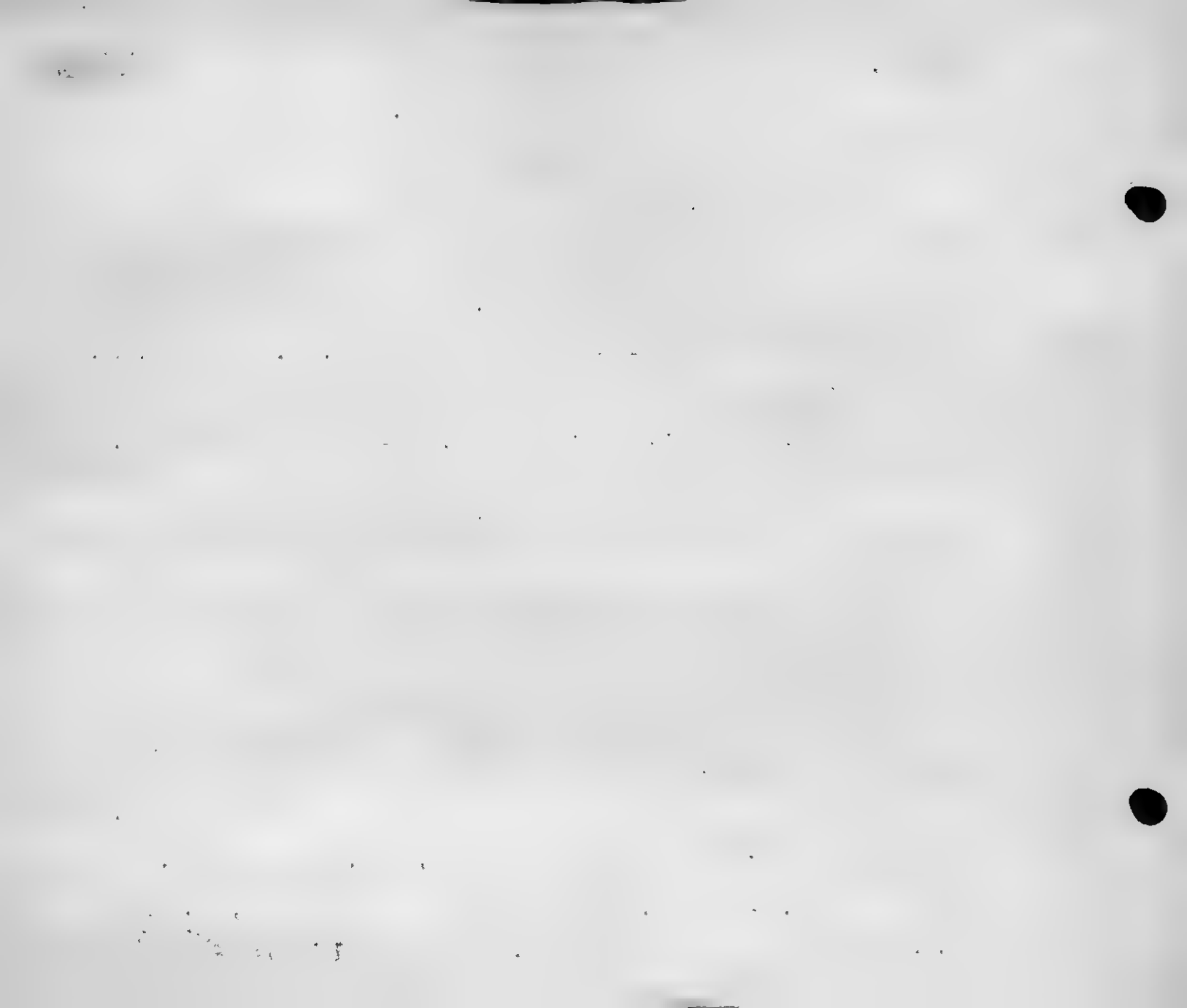
CERTIFICATE OF DEATH

05149

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Frederick	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN b two weeks		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS Route 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie Margaret Perkins		4. DATE OF DEATH Month April Day 5 Year 1967		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3-1883	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas O'Bryan		14. MOTHER'S MAIDEN NAME Not available		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 213-16-0111		17. INFORMANT Donald A. Day- Route 2- Frederick, Md. 21701		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1962 to April 5, 1967 that (I) (we) last saw the deceased alive on April 5, 1967 and that death occurred at 3:15p from the causes and on the date stated above.		22a. SIGNATURE Lt Roy T. Davis M.D.		22b. DATE Apr. 6-1967	
22c. PHYSICIAN'S NAME (Type) Lt Roy T. Davis		22d. ADDRESS Prof. Bldg.- Frederick, Md. 21701		22e. REC'D BY REGISTRAR APR 10 1967	
22f. REGISTRAR'S SIGNATURE J Charles Judge		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 8-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Frederick, Md. 21701		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son		24a. ADDRESS Elwood T. Whitmore		24b. CITY Frederick, Md. 21701	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
20M 1/65

05152

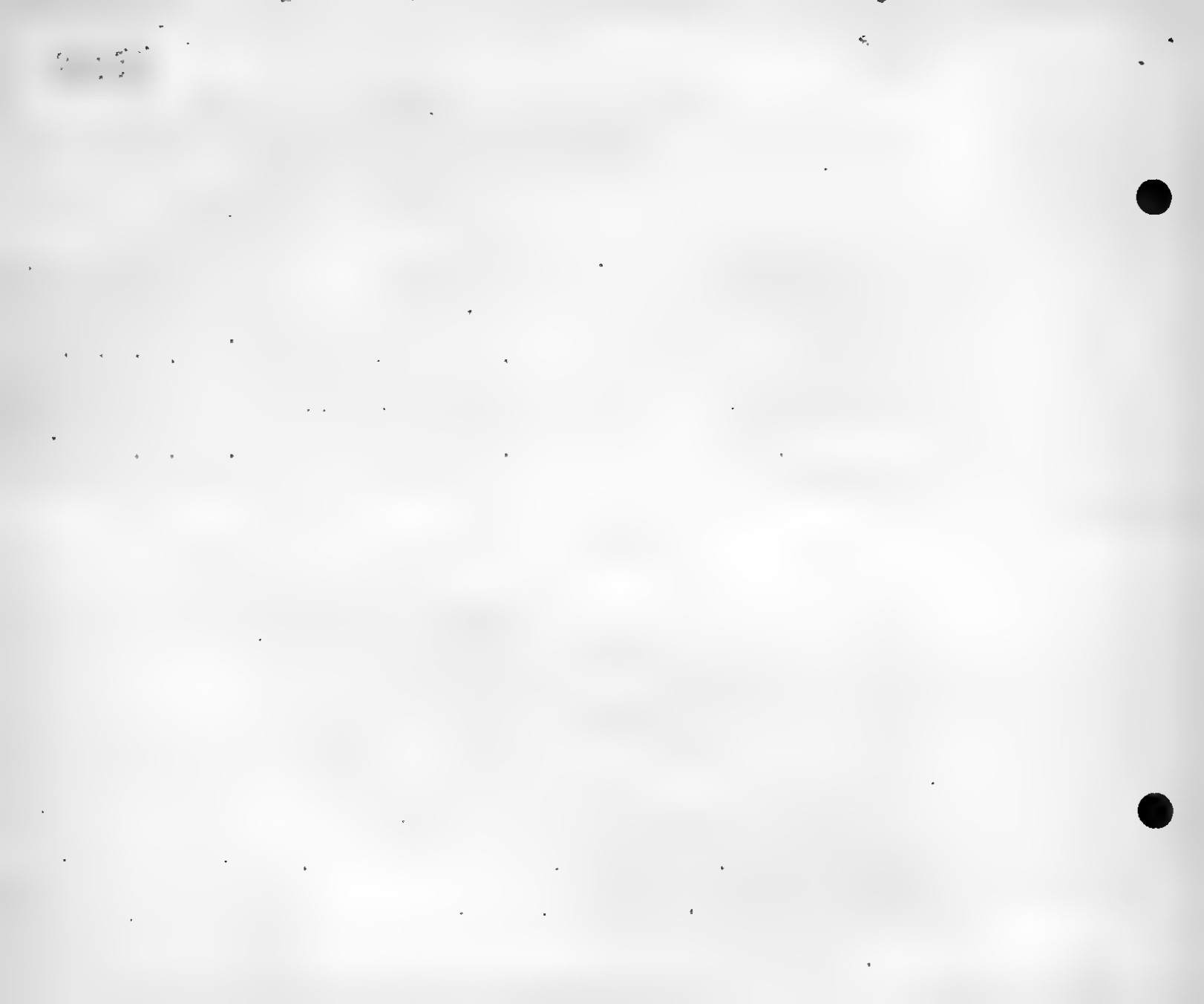
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05150

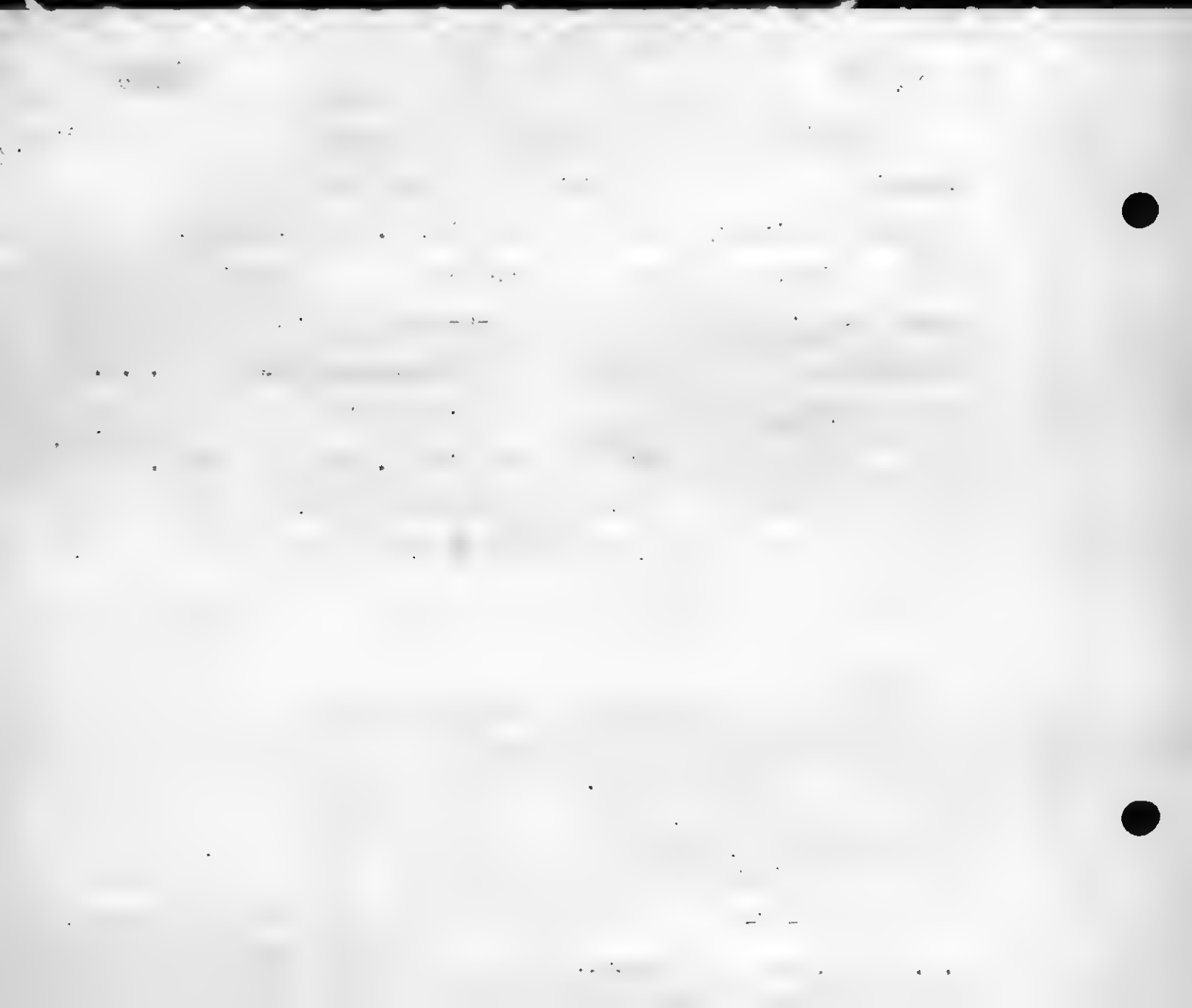
1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 2 Weekd d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 106 East Seventh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle E. Last PETTINGALL				4. DATE OF DEATH Month April Day 20 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1888	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78		IF UNDER 24 HRS. Days 78		Hours 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Ox-Fibre Brush Co.		11. BIRTHPLACE (County & State, or foreign country) Fountain Rock, Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Winfield Pettingall				14. MOTHER'S MAIDEN NAME Margaret Eyler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. #1 214 10 1430		17. INFORMANT Mr. Scott Pettingall, 20 E. 8th St. Frederick, Md.		Address 20 E. 8th St. Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA + UREMIA (b) URINARY TRACT INFECTION (c) CARCINOMA BLADDER - ARTERIO SCLEROTIC HEART PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Disase 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/3 , 19 67 to 4/20 , 19 67 that (I) (we) last saw the deceased alive on 4/20 , 19 67 , and that death occurred at 5:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Thomas				22b. DATE SIGNED 4-20-67		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Robert J. Thomas, M. D.				22e. ADDRESS Toll House Ave. Frederick, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland				25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05153 CERTIFICATE OF DEATH 05151

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN ID 30 yrs				d. STREET ADDRESS 124 W. All Saints St			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montevue Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alzie Poole Randolph				4. DATE OF DEATH April 13 1967			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-1883	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Mongomery Co Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Patrick Warren			
14. MOTHER'S MAIDEN NAME Ellen Lewis				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT William K. Randolph Address Frederick, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerotic vascular disease DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH 4 days, 5 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 14 , 19 66 , to April 13 , 19 67 , that (I) (we) last saw the deceased alive on April 13 , 19 67 , and that death occurred at 6 PM , from the causes and on the date stated above.							
22a. SIGNATURE LE Roy T. Davis				22b. DATE SIGNED 4/14/67			
22c. PHYSICIAN'S NAME (Type) LE Roy T. Davis				22d. ADDRESS Frederick, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-17-67		23c. NAME OF CEMETERY OR CREMATORY Rocky Hill		23d. LOCATION (City, town or county) (State) Clarksburg Montgomery Md	
24. FUNERAL DIRECTOR C.E. Hicks, III ADDRESS Frederick, Md				25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05154					05152				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
a. COUNTY		Frederick			a. STATE		b. COUNTY		
		MARYLAND			Maryland		Frederick		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Union Bridge R.D.		Life			Union Bridge R.D. Md 21791				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					Rural		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
John		Samuel		Repp		4		28 1967	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1-7-1898		69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days	
Farm				Frederick Md		U.S.		Hours Min.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
James Macrellus Repp		May Diehl		No		216-36-6052		Mary Louise Repp	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Atherosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 7 weeks		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO		(b)		DUE TO		(c)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Hypertension							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/8/67 to 4/28/67, that (I) (we) last saw the deceased alive on 4/22/67, and that death occurred at 1234 M, from the causes and on the date stated above.		22a. SIGNATURE J. Caricofe		22b. DATE SIGNED 4/28/67		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR	
Burial		5-1-67		Pipe Creek		Near Uniontown Md		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. DATE		25b. REGISTRAR'S SIGNATURE					
Raymond A. Wright		MAY 3 1967		John Charles Judge					
Union Bridge Md									

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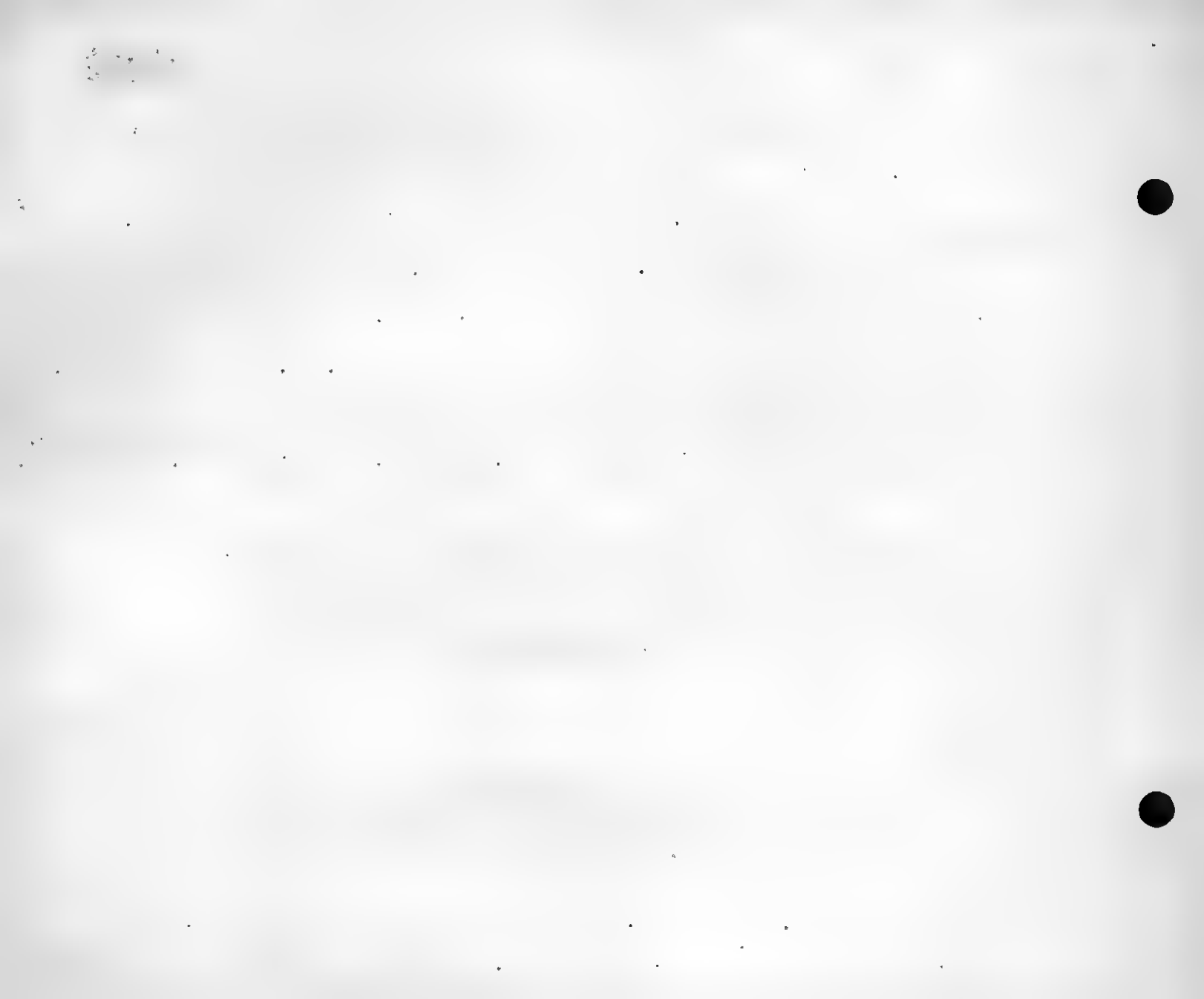
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05155 CERTIFICATE OF DEATH 05153

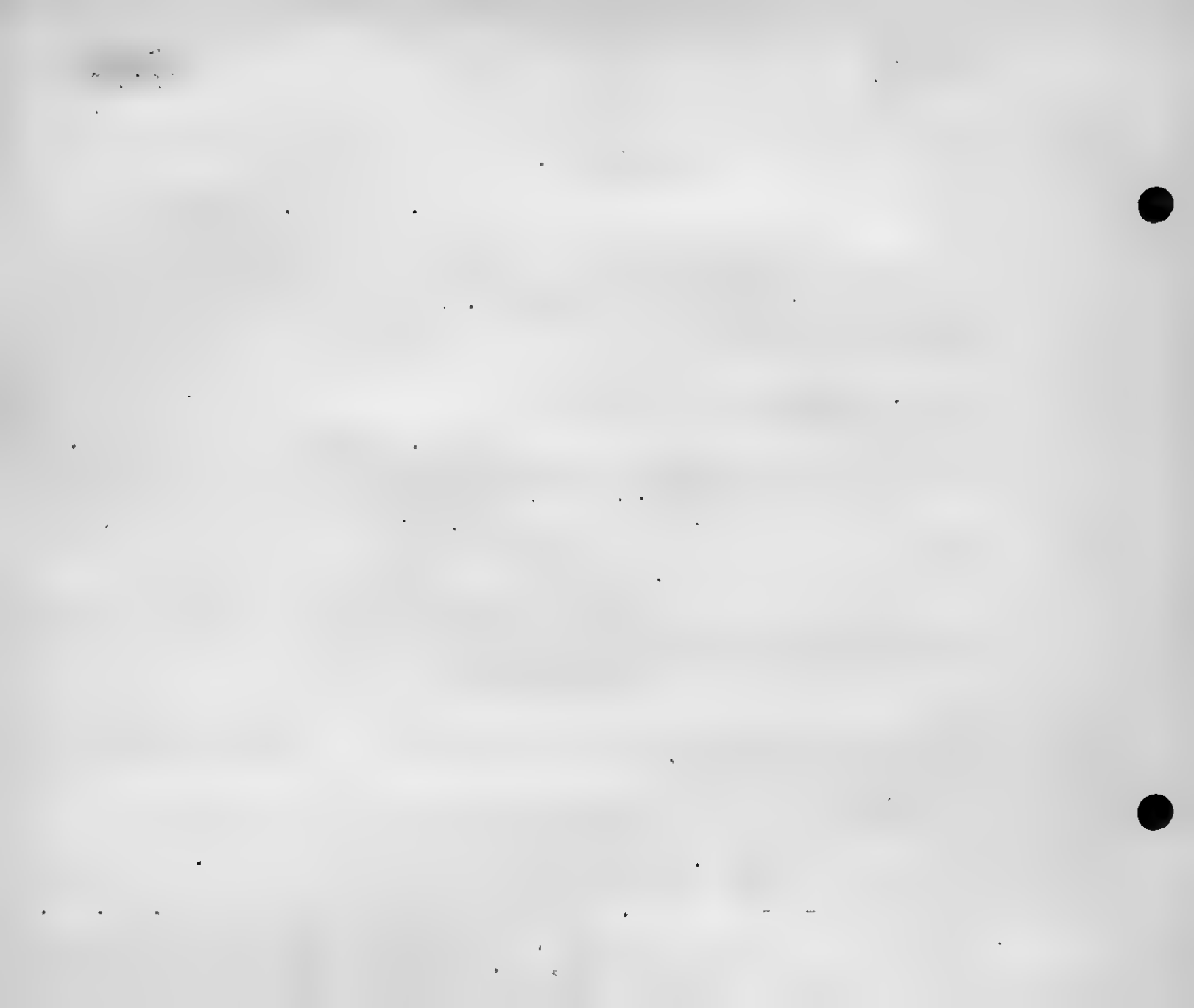
1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN ID Lifetime		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 125 South Fairview Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roy		First Doug		Middle L.		Last Rhoderick		4. DATE OF DEATH Month April		Day 26		Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26-1908		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 		Days 		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Operator		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Joseph Vernon Rhoderick		14. MOTHER'S MAIDEN NAME Ada Schleigh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-26-2336		17. INFORMANT Mrs. Thelma M. Rhoderick-125 S. Fairview Ave.		Address Frederick, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Instant 13 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hypertension		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept 17 , 1954, to April , 1967, that (I) (we) last saw the deceased alive on Apr 25 , 1967, and that death occurred at p. M. from the causes and on the date stated above.		22a. SIGNATURE Thomas E. Stone		22b. DATE SIGNED 4-26-1967		22c. PHYSICIAN'S NAME (Type) Thomas STONE		22d. ADDRESS Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 29-1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Md. 21701									
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR 4-28-1967		25b. REGISTRAR'S SIGNATURE Charles Judge											



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05156 CERTIFICATE OF DEATH 05154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont c. LENGTH OF STAY IN b 50 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Fred-erick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont d. STREET ADDRESS 516 E. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eliza Rhodes First Middle Last 4. DATE OF DEATH April 20 19 67 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Jan. 18, 1874 9. AGE (in years last birthday) 93 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John W. Miller 14. MOTHER'S MAIDEN NAME Elizabeth Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Charles G. Rhodes Address Thurmont, Md. RD2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary Embolus Chronic Phlebitis Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Renal Failure		INTERVAL BETWEEN ONSET AND DEATH immediate 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1958 to 4-20, 1967 , that (I) (we) last saw the deceased alive on 4-19-67 , and that death occurred 730 AM , from the causes and on the date stated above 22a. SIGNATURE Thomas A. Love M.D. 22c. PHYSICIAN'S NAME (Type) Thomas A. Love		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Thurmont, Md. 22b. DATE SIGNED 4/20/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4-24-67 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery 23d. LOCATION (City, town or county) (State) Thurmont Fred. Co. Md.		24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager ADDRESS Thurmont, Md. 25a. REC'D BY REGISTRAR APR 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

05157

05155

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS 519 North Market Street	
3 NAME OF DECEASED (Type or print) First LOUISE Middle HALLAR Last RODERICK		4. DATE OF DEATH Month April Day 1 Year 19 67	
5. SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept 1899
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant to Supt.		10b. KIND OF BUSINESS OR INDUSTRY County Home	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William T. Hallar		14. MOTHER'S MAIDEN NAME Louisa C. Eckstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215 14 2770	
17. INFORMANT William O. Best, Rockville, Md. 20850		18. ADDRESS 815 W. Montgomery Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1950 Congestive Heart Failure DUE TO (b) Carcinomatosis DUE TO (c) Adrenal Cortical Carcinoma			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 24, 19 65 to April 1, 19 67 , that (I) (we) last saw the deceased alive on March 23, 19 67 , and that death occurred at 6 A M, from causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		22b. DATE SIGNED 1 April 1967	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D.		22d. ADDRESS 804 Tell House Ave., Fred'k, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/4/67	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR DATE APR 4 1967	25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05158

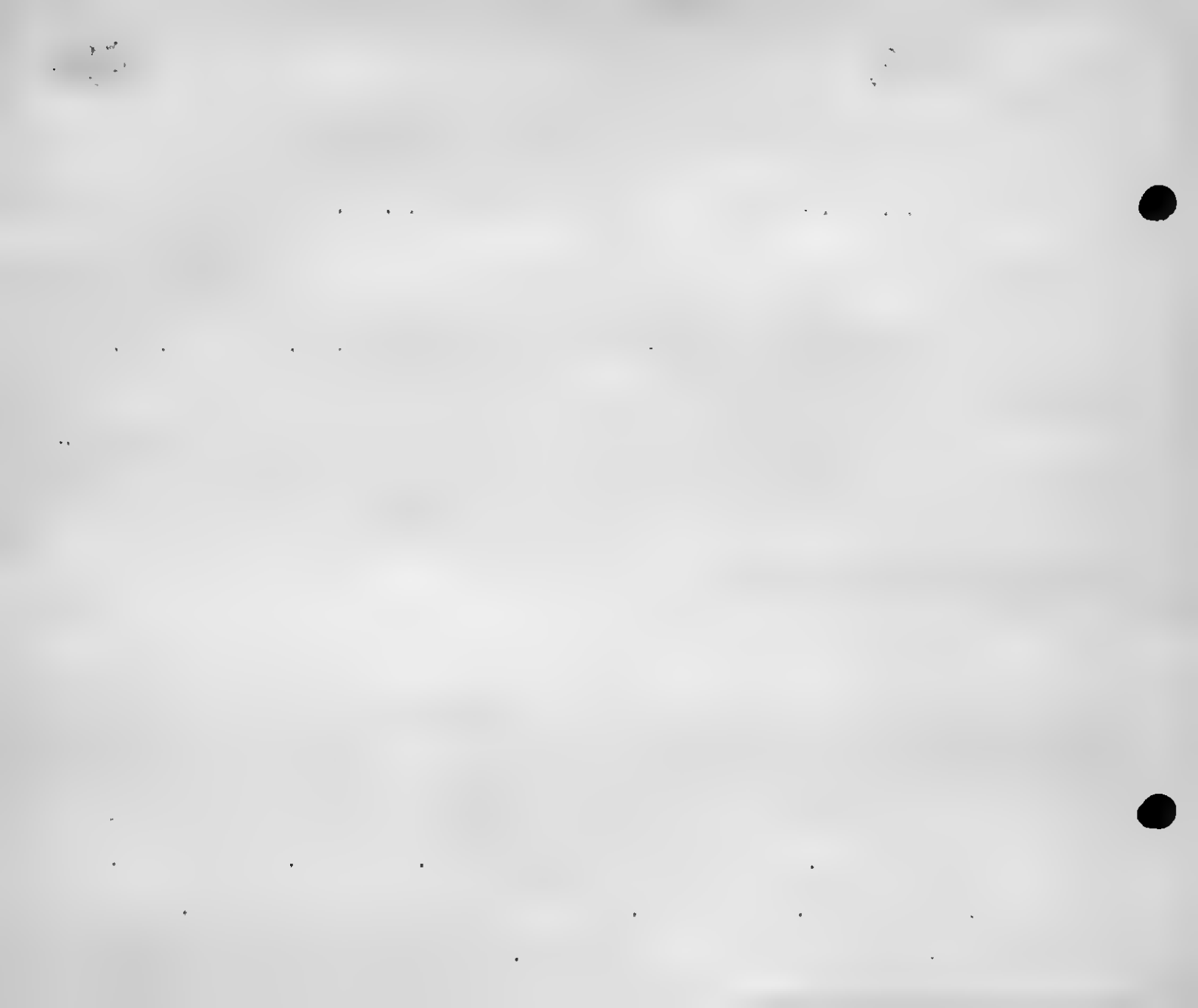
CERTIFICATE OF DEATH

05156

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> <u>101</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frederick Memorial Hospital</u>		d. STREET ADDRESS <u>310 Willow Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Strobel</u>		4 DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/27</u>
9 AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>installer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>telephone co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Mr. Milton C. Strobel (D)</u>		14. MOTHER'S MAIDEN NAME <u>Edith Mumford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO <u>W.W.II</u>	
17. INFORMANT <u>Mrs. Naomi Strobel, Frederick, Md.</u>		Address <u>310 Willow Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mitotic Carcinoma, brain</u> DUE TO (b) <u>Benign Carcinoma Lung</u> DUE TO (c) <u>10-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1955</u> to <u>4/19/67</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1967</u> , and that death occurred at <u>12:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Bernard O. Thomas, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/19/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Bernard O. Thomas, Jr.</u>		22d. ADDRESS <u>Frederick, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>4/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Middletown, Fred., Md.</u>
24. FUNERAL DIRECTOR <u>Gladhill Company, Middletown, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE APR 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05160

CERTIFICATE OF DEATH

05158

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Market		101	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		d. STREET ADDRESS New Market, Maryland 21774	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ARTHUR EDWARD STRUBE, SR.		4 DATE OF DEATH Month Day Year April 27, 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1878
9 AGE (In years last birthday) 89 yrs		11 BIRTHPLACE (County & State, or foreign country) Frederick, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Andrew Strube		14. MOTHER'S MAIDEN NAME Rose Schrodle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217 12 2864	
17. INFORMANT Carlton L. Strube, Ijamsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Serulitis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 5 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 54 to 4-27-1967 , that (I) (we) lost saw the deceased alive on 4-26-1967 , and that death occurred at 2:15 P.M. , from causes on and on the date stated above.			
22a. SIGNATURE Rex R. Martin, M.D.		22b. DATE SIGNED April 27, 1967	
22c. PHYSICIAN'S NAME (Type) Rex R. Martin, M.D.		22d. ADDRESS 220 N. Market Street, Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 29, 1967	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Maryland
24 FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		25. REC'D BY REGISTRAR APR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05161

CERTIFICATE OF DEATH

05159

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 248 Dill Avenue		d. STREET ADDRESS 248 Dill Avenue	
3. NAME OF DECEASED (Type or print) KATHERINE S. STULL		4. DATE OF DEATH Month April Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1897
9. AGE (in years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Schade		14. MOTHER'S MAIDEN NAME Clementine Runkles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-46-5244	
17. INFORMANT Mr. Leslie Stull		Address 248 Dill Ave. Frederick, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic heart disease with an acute myocardial infarct DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-23, 1966 , to 4-6, 1967 , that (I) (we) last saw the deceased alive on 4-6-1967 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Rex R. Martin		22b. DATE SIGNED April 6, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		22d. ADDRESS 220 N. Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-8-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR Frederick, Md.	
25b. REGISTRAR'S SIGNATURE James Judge		DATE APR 10 1967	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

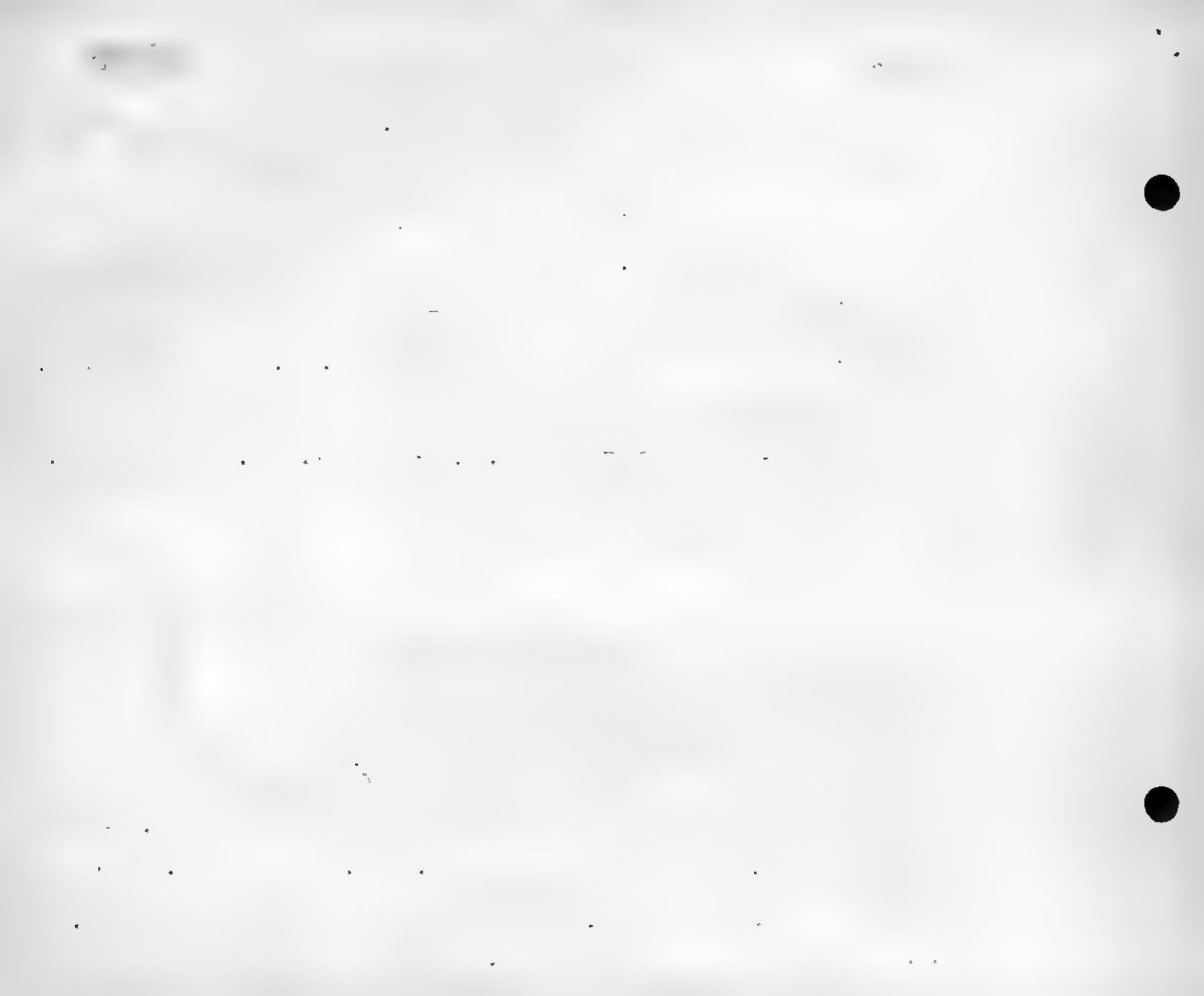
05160

35162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Frederick b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick- Rural d. STREET ADDRESS Route 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Pearl G. Stull		4. DATE OF DEATH Month Day Year April 29-- 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22-1895
9 AGE (In years last birthday) yrs 71		10. IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY -----	
11 BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Washington Spurrier		14. MOTHER'S MAIDEN NAME Sarah Emma Rippeon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 220-48-0780	
17 INFORMANT Mrs. R. Herbert Oden- Rt. 6-Frederick-Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO (b) Cerebral arteriosclerosis DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 hour years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 to 4/29, 1967 , that (I) (we) lost saw the deceased alive on 4/29, 1967 , and that death occurred at 7:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE James B. Thomas		22b. DATE SIGNED Apr. 29-1967	
22c. PHYSICIAN'S NAME (Type) James B. Thomas		22d. ADDRESS Prof. Bldg.-Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 2-1967	23c. NAME OF CEMETERY OR CREMATORY Marvin Chapel Cemetery	23d. LOCATION (City or Town) (County) (State) Plane #4- Frederick-Md.
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR MAY 5 1967	
ADDRESS Whitmore Frederick, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

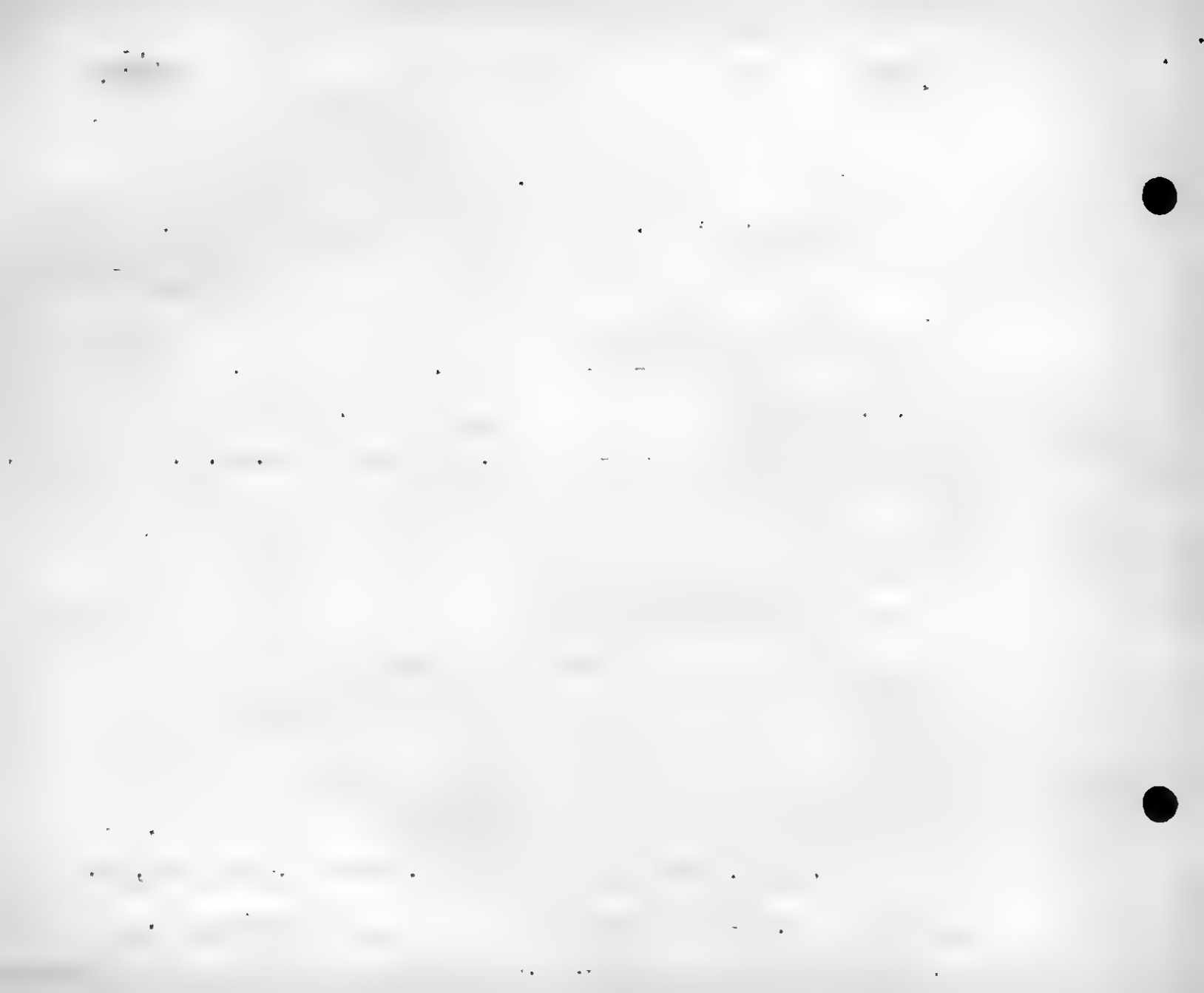
05163

05161

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb about 2yrs.	
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) 14 West Thirteenth St.		d. STREET ADDRESS 14 West Thirteenth St.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Stoneburner Titus		4. DATE OF DEATH Month Day Year April 14- 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26-1889
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Mr. Lovettsville-Va.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. C. Stoneburner		14. MOTHER'S MAIDEN NAME Sallie E. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219- 46- 3650	
17. INFORMANT Address Mrs. Guy Greager-1214 N. Mkt. St.-Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Systolic aortic atherosclerotic heart disease - acute myocardial infarct. 4201 DUE TO (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. heart - pt. had been under the care of Dr. J. J. Zucchi +		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) was seen recently by him.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 6 A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Rex R. Martin		22b. DATE SIGNED Apr. 14-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		22d. ADDRESS 220 N. Market St.- Frederick, Md. 21701	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 17-1967	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Lovettsville- Va.
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REGISTERED BY REGISTRAR APR 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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05164

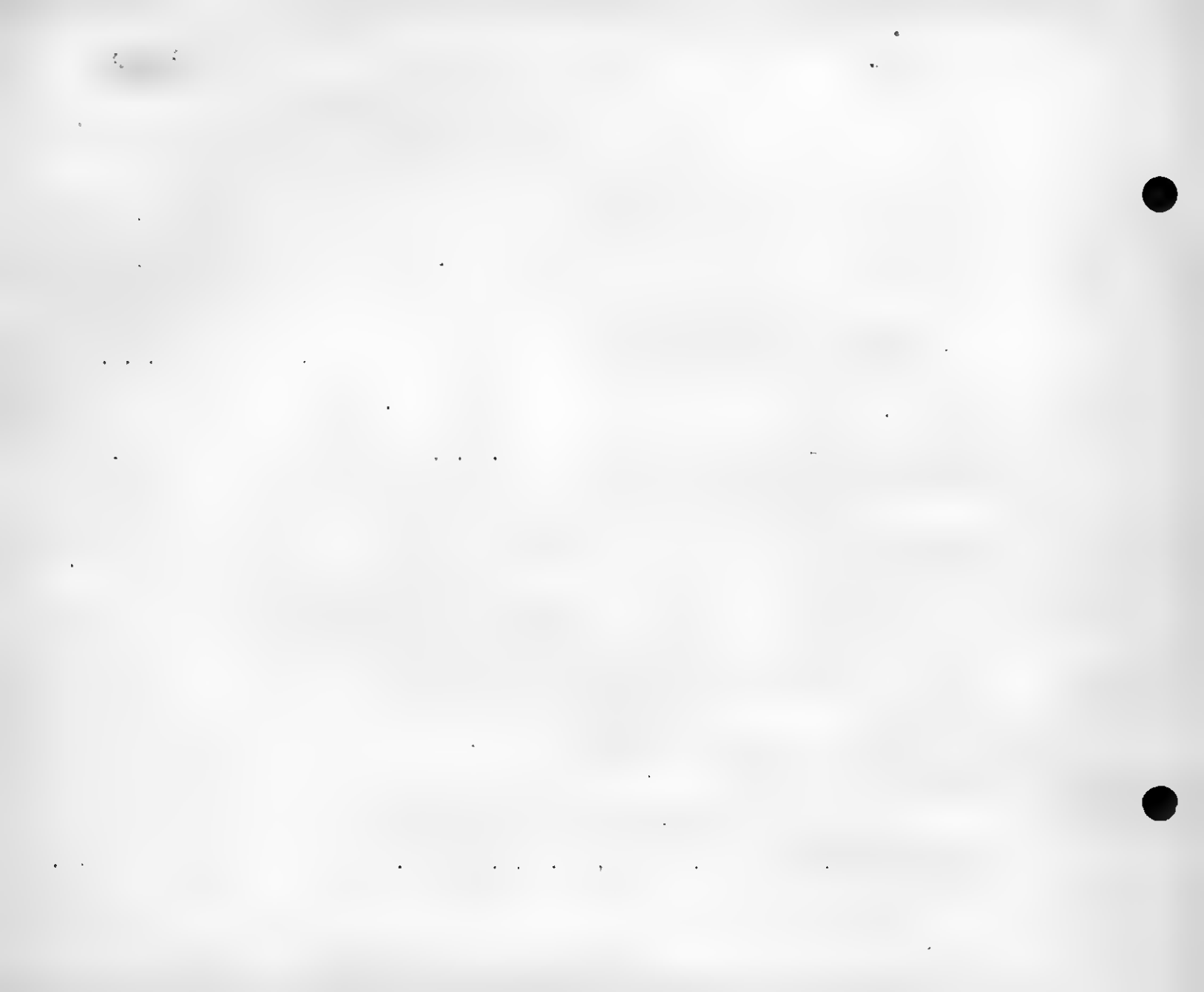
CERTIFICATE OF DEATH

05162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Two Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Nursing Center		d. STREET ADDRESS 207 South Washington St.	
3. NAME OF DECEASED (Type or print) BERTHA ^{First} THOMAS ^{Middle} TRUNDLE ^{Last}		4. DATE OF DEATH Month April Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1880
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teacher	
11. BIRTHPLACE (County & State, or foreign country) Point of Rocks, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph H. Trundle		14. MOTHER'S MAIDEN NAME Emily B. Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-6297	
17. INFORMANT Mrs. E.O. Gardner		Address Rockville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 410 X IMMEDIATE CAUSE (a) Ch. Congestive heart failure DUE TO (b) Myocardial Infarction DUE TO (c) Rheumatic heart dis (?)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 40+ yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 30 Apr , 19 67 , that (I) (we) last saw the deceased alive on 30 April 1967 , and that death occurred at 7:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Conley, Jr.		22b. DATE SIGNED April 8, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr. M.D.		22d. ADDRESS 228 N. Market Street Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-11-1967	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR Robert E. Dailey & Son		25a. REC'D BY REGISTRAR APR 13 1967	
ADDRESS Frederick, Maryland		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05168

1 PLACE OF DEATH a. COUNTY Frederick MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hopehill		c. LENGTH OF STAY IN 1b 15 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt 2 Hopehill Frederick Co		e. STREET ADDRESS Rt 2	
3 NAME OF DECEASED (Type or print) Ruth Ann Diggs Tucker		4 DATE OF DEATH 4 10 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-15-1887
9 AGE (In years last birthday) 80 yrs		10 IF UNDER 1 Year Months Days Hours Min.	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switch Board Op.		11b KIND OF BUSINESS OR INDUSTRY *****	
11c BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Clayton Diggs		14. MOTHER'S MAIDEN NAME Rachel Crampton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No *****		16 SOCIAL SECURITY NO 212-32-1437	
17 INFORMANT Edgar Diggs		Address Rt 2 Frederick Co, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert J. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert J. Thomas, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4/10/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4-12-1967	
23c NAME OF CEMETERY OR CREMATORY Hopehill		23d LOCATION (City or Town) (County) (State) Frederick Md	
24 FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Md		25a REC'D BY REGISTRAR APR 12 1967	
		25b REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> c. LENGTH OF STAY IN b. <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Frederick Memorial</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u> d. STREET ADDRESS <u>204 Park Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Carl M. Van Poole</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 21, 1927</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>				11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, N.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Chalmers M. Van Poole</u>						14. MOTHER'S MAIDEN NAME <u>Mary E. Linn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW 1</u>				16. SOCIAL SECURITY NO. <u>600-00-0705</u>		17. INFORMANT <u>Mrs. E. M. Van Poole</u>				Address <u>As #</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Malignancy</u> (b) <u>Carcinoma of stomach</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>3-4 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1967</u> to <u>April 30, 1967</u> that (I) (we) last saw the deceased alive on <u>April 30, 1967</u>, and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry V. Chase</u>						22b. DATE SIGNED <u>30 April 67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>						22d. ADDRESS <u>Box 204 Tall House Ave Frederick Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/4/1967</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Pine Grove</u>		23d. LOCATION (City, town or county) (State) <u>Mt. Airy, Md.</u>					
24. FUNERAL DIRECTOR <u>C.M. Waltz Box 241 Sykesville, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05165

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY Cayuga ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Emmitsburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martville, 693	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Maude Middle S. Last Vine			4. DATE OF DEATH Month April Day 11 Year 1967 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1880	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Victory, N.Y.	
13. FATHER'S NAME Homer Blanchard			14. MOTHER'S MAIDEN NAME Helen Kaykendall		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Mrs. Evelyn Worboys, Martville, N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Lacerated Heart & Aorta 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed Chest DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto - struck pole head-on			
20c. TIME OF INJURY Month, Day, Year 3:30 p.m. 4-11-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
		20f. (City or town) (County) (State) Emmitsburg - Frederick Md			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert J. Thomas		M.D.		22. DATE SIGNED 4-11-67	
EXAMINER'S NAME (Type) Robert J. Thomas		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Martville Cemetery	
				23d. LOCATION (City or Town) (County) (State) Martville, Cayuga Co. N.Y.	
24. FUNERAL DIRECTOR Clarence E. Wilson		ADDRESS Emmitsburg, Md.		25a. REC'D BY REGISTRAR APR 13 1967	
				25b. SIGNATURE John J. [Signature]	

MEDICAL CERTIFICATION

00125

00125



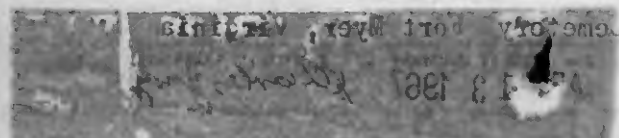
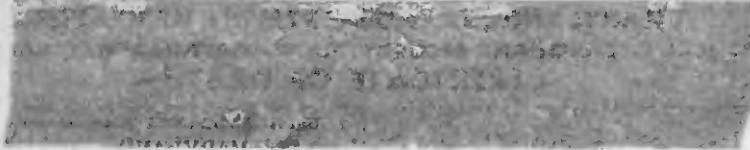
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
05168					05166							
1. PLACE OF DEATH a. COUNTY FREDERICK b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXSON Rural Frederick years c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route # 6 Frederick					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXSON Rural Frederick d. STREET ADDRESS Route # 6 Frederick e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EVERS Middle Phillip Last ZEPP			4. DATE OF DEATH Month APRIL Day 9 Year 19 67									
5. SEX MALE		6. COLOR OR RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1912		9. AGE (In years last birthday) 54		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF Ret'd				10b. KIND OF BUSINESS OR INDUSTRY US Air Force				11. BIRTHPLACE (County & State, or foreign country) Martinsburg, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Franklin Zepp					14. MOTHER'S MAIDEN NAME Ida Virginia Trager							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes 1934 - 1955				16. SOCIAL SECURITY NO. 231-42-5814		17. INFORMANT Address Mrs. Adeline E. Zepp Rt. # 6 Frederick, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of neck DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None										INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 mos.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 19..... to 19....., that (I) (we) last saw the deceased alive on 19....., and that death occurred at.....M, from the causes and on the date stated above.												
22a. SIGNATURE Boris A. Reisberg M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 9 Apr 67				
22c. PHYSICIAN'S NAME (Type) BORIS A. REISBERG, CPT, MC					22d. ADDRESS USA Medical Unit, Ft Detrick, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4-12-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			23d. LOCATION (City, town or county) (State) Fort Myer, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son					ADDRESS Frederick, Maryland			25a. DIED BY REGISTRAR APR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

02182

02182



Handwritten signature or scribble